UNIVERSITY OF CALIFORNIA
MEDICAL CENTER LIBRARY
SAN FRANCISCO

EX LIBRIS

Digitized by the Internet Archive
in 2016 with funding from
The National Endowment for the Humanities and the Arcadia Fund

https://archive.org/details/marylandstatemed02unse

MARYLAND
STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

1211 Cathedral Street, Baltimore 1, Maryland
Official Publication of the Medical and Chirurgical Faculty of the State of Maryland

Maurice C. Pincoffs, M.D., *President,*
George H. Yeager, M.D., *Secretary*
J. Albert Chatard, M.D., *Treasurer*

Osborne D. Christensen, M.D.
George O. Eaton, M.D.
William F. Williams, M.D.
Vice-Presidents

EDITOR
GEORGE H. YEAGER, M.D.

EDITORIAL BOARD

Leslie E. Daugherty, M.D., Cumberland
Hugh J. Jewett, M.D., Baltimore
William B. Long, Salisbury

Emil Novak, M.D., Baltimore
John A. Wagner, M.D., Baltimore
A. Earl Walker, M.D., Baltimore

Walter N. Kirkman, Baltimore, *Business Manager*

Index to VOLUME 2

January to December, Inclusive, 1953

January—Pages	1 to 54
February—Pages	55 to 106
March—Pages	107 to 164
April—Pages	165 to 222
May—Pages	223 to 292
June—Pages	293 to 348
July—Pages	349 to 398
August—Pages	399 to 482
September—Pages	483 to 526
October—Pages	527 to 572
November—Pages	573 to 622
December—Pages	623 to 679

MARYLAND
STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

1211 Cathedral Street, Baltimore 1, Maryland
Official Publication of the Medical and Chirurgical Faculty of the State of Maryland

Maurice C. Pincoffs, M.D., *President*
George H. Yeager, M.D., *Secretary*
J. Albert Chatard, M.D., *Treasurer*

Osborne D. Christensen, M.D.
George O. Eaton, M.D.
William F. Williams, M.D.
Vice-Presidents

EDITOR
GEORGE H. YEAGER, M.D.

EDITORIAL BOARD
J. Tyler Baker, M.D., Easton
Leslie E. Daugherty, M.D., Cumberland
Hugh J. Jewett, M.D., Baltimore
Emil Novak, M.D., Baltimore
John A. Wagner, M.D., Baltimore
A. Earl Walker, M.D., Baltimore
Walter N. Kirkman, Baltimore, *Business Manager*

Index to VOLUME 1

January to December, Inclusive, 1952

January—Pages	1 to 48	July—Pages	315 to 366
February—Pages	49 to 120	August—Pages	367 to 428
March—Pages	121 to 174	September—Pages	429 to 482
April—Pages	175 to 214	October—Pages	483 to 536
May—Pages	215 to 266	November—Pages	537 to 578
June—Pages	267 to 314	December—Pages	579 to 642

95012

INDEX TO MARYLAND STATE MEDICAL JOURNAL[*]

VOLUME 1, 1952

ACTH and cortisone, contraindications to, panel discussion, 485—501
Abbott, Osler A., Speaker, annual meeting, 122
Adoption law of Md., symposium on medical aspects announced, 599
Alcoholism, a medical and social problem (Lemkau), 467
Allan, Warde B.: Report of the A.M.A. convention in Atlantic City, 401
Allegany-Garrett County Medical Society, 250, 299, 341, 458, 515, 561, 599, active members, 615
Allen, J. Garrott: Pooled plasma and homologous serum jaundice, 540–7
American Diabetes Association, announces prize for paper on diabetes, 560
American education, brief suggestions for meetings, readings, (Woman's Aux.), 577
American Medical Association
  offers aid to doctors discharged from military service, 519
  secretary's letter, medical education expansion program survey, 258
  structure and functions of the, 439
  You and your A.M.A., You are the A.M.A. (Martin), 436–9
American Medical Association, Woman's Auxiliary national convention notes (Williams), 528–30
American Medical Education Foundation (Day), 219–20, 513
American Medical Education Foundation
  grants to medical schools, 538
  report of the reference committee on medical education and hospitals adopted, 538
American Nurses Association, 1952 biennial convention, 480
American Pharmaceutical Association, celebrates 100th anniversary, 535–6
Ancillary news, see allied societies, such as Baltimore City Dental Society, etc.
Anne Arundel County Medical Society, 97, 156, 250, 341, 515, active members, 615–6
Asper, Samuel P., Jr.: Radioactive iodine, 233–4
Atomic attack, the physician against (Wilson), 182–6
Aureomycin, abscess of the lung . . . treated by surgery and, (Ginsburg), 295–8
Auxiliary nursing scholarships, 208

Baker, Samuel, the Dr. Samuel Baker Fund, 521
Ball, Mrs. John G.: Program (of the Woman's Auxiliary), 476
Ballin, Ralph W.: Letter to the editor, 365
Baltimore City Dental Society (Eskow), 264, officers, 362, 479, 533
Baltimore City Health Department
  fluoridation approved for city water, 256–8
Baltimore City Health Department (Continued)
  new communicable disease chart (Williams), 109
  new toxoid program, 597
Baltimore City Medical Society, 28–9, 32, 156, 159, 299, 516
  Active members, 627–42
  Anesthesiology section, 28, 98, 157, 211
  Cancer section, established, 223; meeting, 427
  Committee for the study of pelvic cancer, 29, 100, 150–2, 160, 176–9, 272–4
  Committee on public medical education, Capitol capsules (Hopkins), 221–3
  Dermatological section, 100
  Maternal mortality meeting, 29, 100, 160
  Neuropsychiatric section, 29, 100, 159
  Ophthalmological section, 28, 99, 158, 299–301
  Orthopaedic section, 99, 160, 211
  Otolaryngological section, 99, 600
  Panel discussion: blood dyscrasias, announcement of, 600
  Panel discussion: diets, announcement of, 516
  Pathology section, 29, 100, 160, 211, 459–60
  Pediatric section, 100, 600
  Radiological section, 101, 157, 160, 211, 342
  Schedule for annual meeting, 566
  Section of diseases of the chest, 99, 157, 516, 600
  Semiannual meeting, 159
  Surgical section, 158, grievance committee (Blue Shield), 516, officers, 516
  Symposium on medical aspects relating to euthanasia, announcement, 101
  Symposium on the use and misuse of blood transfusion in surgery, 540–55
  Urology section, 29
  Woman's Auxiliary, 29, 159, 558
Baltimore County Medical Association, 160, 250, 301, 342, 460, 517, 562, 601
  Active members, 616–8,
  history of (Medairy), 563–4
Baltimore Veteran's Administration Hospital, nursing service staff, 534–5
Barker, Lewellys Franklin, Barker fund, 602–3
Basic sciences, as they apply to the practice of medicine, course in, University of Maryland, 427
Baumgartner, Mrs. E. Irving: Auxiliary civil defense program, 116–7
Bearborn, Earl H.: Pharmacology of drugs causing addiction, 21–4
Berthrong, Morgan: Pathology (thyroid), 231–2
Bibliography: recent publications by faculty members, 35–7, 165–6, 202–3, 345–6, 568–9
Blood transfusion in surgery, symposium on the use and misuse of, 540–55

---

[*] Index compiled by the Library Staff of the Medical and Chirurgical Faculty.

Blood transfusions, untoward reactions from (Conley), 547–52
Blue Cross, 112, 259, 308, 353
  enrollment, 483
  membership, 526
  payments for hospital care, 526
  subscribers hospitalized, 526
  summary of the plan, 483–4
Blue Cross and Blue Shield; a progress report (Dabney), 526
Blue Cross and Blue Shield, annual dinner, 168
Blue Shield
  discussion of the service benefit plan (Dabney), 575
  enrollment, 483
  membership, 526
  payments to physicians, 526
  President's report to board of trustees (Jewett), 204
  progresses, 44
  revision in benefits, 475, 483
  subscribers receiving benefits, 526
  Support the (Everett), 339
  Why physicians support (Dabney), 605
Book collections, Disposition of, 165
Bookplates—The Finney fund (Duffield), 305; Osler funds, 344
Bowel, large hemorrhages from the, of obscure origin (Stone), 555–8
Bursitis, cortisone (cortone) in the treatment of acute subdeltoid (Friedman), 186

Calvert County Medical Society, 101, active members, 618
Campbell, William D.: Washington County Medical Society, 302–4
Capitol Capsules (Hopkins), 221–3
Capitol Clinic, A.M.A., excerpts from
  Court rules that key sections of lobbying law are unconstitutional, 249
  Defense department to survey country's research potential, 348
  F. S. A. officials discuss vocational rehabilitation budget problems, 348
  Federal, state medical stockpiles may exceed $80 million by mid-year, 263
  House committee cuts VA medical budget, 213
  Mrs. Rosenberg says dependents of servicemen are getting less medical care, 213
  Murray and Dingell introduce bills for hospitalization-at-age-65, 314
  National Advisory committee cautions hospitals on selecting residents, 213
  Only four "Critical Target" states not active in CD medical stockpiling, 214
  Senate committee approves continuation of special pay for doctors, 351
  Senate committee increases PHS appropriation by almost $4.5 million, 361
Capitol Clinic, A.M.A., excerpts from (Continued)
  Senate Health Subcommittee action on EMIC Bills promised "fairly soon," 214
  70% of Federal civil defense funds go for medical purposes, 356
  Supreme Court rules in favor of Oregon Medical Society, 340
  U. S. Chamber of Commerce advocates draft deferments for medical students, 351
  War Manpower Council urges military deferment through year of residency, 364
Carey, T. Nelson: Internal medicine (thyroid), 228–9
Carliner, Paul E.: Emergency medical call system for Baltimore City and Baltimore County, 514
Caroline County Medical Society, 101, active members, 618
Carroll County Medical Society, 101–2, 342, 565, active members, 618
Cecil County Medical Society, 161, active members, 618–9
Chalfant, Mrs. A. S.: Are you registered to vote?, 361; Good public relations, 207
  What about our American education?, 607–8
Charles County Medical Society, 30, 161, active members, 619
Chatard, J. Albert:
  Message from the Treasurer, 6
  Past—Present—Future, 146–9
  appointed Curator, Medical and Chirurgical Faculty, 398
Chesney, Alan M.:
  Medical education and medical research are part and parcel of the medical profession, 369–377
  Message from the President, 267
  Message from the President; hail and farewell!, 579–80
  Speaker, annual meeting, 122
Chloramphenicol therapy, status of (Woodward), 537–8
Cholecystography using telepaque (Zangara, Davidson and Kilby), 593–6
Chronically ill, some observations of the British system of caring for the aged and (Riley), 465–67
Civil defense
  Auxiliary program (Baumgartner), 116
  bibliography, 463–4
  casualty clearing stations (Williams), 107–8
  Federal, state medical stockpiles, 263
  Maryland (Williams), 347–48
  Maryland medical services (Riley), 10–13
  Medical profession and (Davis), 108
  Physician against atomic attack (Wilson), 182–86
Committee for the study of pelvic cancer, see Baltimore City Medical Society
Communicable disease chart, Baltimore City Health Dept., revised April 20, 1951, 109
Communicable disease report. Maryland State Health Dept., 255, 352, 428, 474, 525, 574, 598
Comparison of the Republican and Democratic party platforms, 457

Compton, Beverley C.: Committee for the study of pelvic cancer, 52, 150–152, 176–79, 272–74
  Committee on scientific work and arrangements, 50
Compton, Mrs. Beverley C.: Creative Arts Show, Woman's Auxiliary, 171
Conley, C. Lockard: Untoward reactions from blood transfusions, 547–52
Cortisone, contraindications to ACTH and, 485–501
Cortisone (cortone) in the treatment of acute subdeltoid bursitis (Friedman), 186–88
Cortisone, selected bibliography, 502–3
Coughlan, Robert E., Jr.: Expert testimony from the viewpoint of trial counsel, 191–5
Courtney, Margaret: Student nurse recruitment, 118
Creative arts show (Compton), 171

Dabney, Reginald H.: Blue Cross, 353
  Blue Cross and Blue Shield, 575
  Why more than 1,600 Maryland physicians support Blue Shield, 605
Daley, Sir William Allen, speaker, annual meeting, 122
Davens, Edward: Conservation of hearing in the counties, 570–573
Davidson, Charles M., jt. auth. see Zangara, H. F.
Davis, J. Wilfrid: Medical profession and civil defense, 108
Day, Newland E.: American Medical Education Foundation, 513–4
  Committee to cooperate with the American Medical Education foundation, 219–220
  No longer our ivory towers, 180–181
  Open letter to the Woman's Auxiliary, 530
Deafness, prevention of, in counties of Md., 570–3
Dermatitis, mushroom (Hopkins), 504–5
Diabetes, prize for paper on, 560
Diabetes Detection Week, announcement, 505
Directory, Medical and Chirurgical Faculty of Maryland, 613–42
Disposition of book collections (Duffield), 165
Dixon, William T.: Psychiatry (thyroid), 225–226
Doctor-citizen in 1952 (Firor), 274–276
Doctor draft debated, 610
Doctor in court (symposium), 190–201, 282–295
Doctor Julius Friedenwald Memorial Lecture, 481
Doctors, Public Health Service, lose military status, 575
Dolce, Joseph R., jt. auth., see Marek, Charles B.
Dorchester County Medical Society, 102, 517–8; active members, 619
Drug addiction, medicolegal symposium, 21–7, 78–91
  Pharmacology of drugs causing (Dearborn), 21–4
  Prosecution of drug cases (Sodaro), 25–7
Drugs, amendment to the Federal Food, Drug and Cosmetic Act (Kantner), 47
Drugs, Durham-Humphrey act (Kantner), 362–3, 612
Drugs, traffic in; problems presented to the youth of the community (Thomsen), 87–9
Dues to medical societies, a reminder, 581
Duffield, Pauline: How the library can serve the physician, 164
  Finney fund, 305
  Hints for medical writers, 306
  Library, 1930–1950, 34

Eaton, George O.: Expert testimony from the viewpoint of traumatic surgery, 199–201
Economics, medical: Private or government control of the practice of medicine (Moyers), 51–2
Editorials
  Comments (Yeager), 49
  Don't be derelict, 175
  A good doctor is a good citizen, 175
  Message from the president; hail and farewell (Chesney), 579–80
  Something to vote about, 215
  Status of chloramphenicol therapy (Woodward), 537–8
  Transactions (Yeager), 367
Education, Medical, and medical research are part and parcel of the medical profession (Chesney), 369–77
Education, Medical, Committee to cooperate with the American Medical Education Foundation (Day), 219–20
Education, Medical, Expansion program survey (Secty's letter), 258
Edwards, C. Reid: Surgery (peptic ulcer), 64–8
  Statement by the chairman of the council, *Maryland State Medical Journal*, 7
Emergency medical call system for Baltimore City and Baltimore County (Carliner), 514
Eskow, A. Bernard: Baltimore City Dental Society journal representative, 264, 362, 479, 533
Everett, Houston S.: Support the Blue Shield, 339

Federal Security Agency regional medical director, name and address, 558
Fellowships, medical research, 569
Finesinger, Jacob E.: Psychiatry (peptic ulcer), 59–61
Finney, John Miller Train, Jr., Finney fund committee, 105
Finney fund bookplate (Duffield), 305
Firor, Whitmer B.: Doctor-citizen in 1952, 274–6
Fluoridation approved for city water supply (Baltimore City Health Dept.), 256
Fonerden, John, the first librarian, Medical and Chirurgical Faculty library, 520
Francis, W. W.: Letter to the editor, 365
Frederick County Medical Society, 102, 518–9; active members, 619–20
Frick, Charles, Frick Reading Room, 462
Frick, William F., Frick endowment fund, 462
Friedenwald, Dr. Julius, Memorial Lecture, 481

Friedman, Marion: Cortisone (cortone) in the treatment of acute subdeltoid bursitis, 186
Fritz, Herbert G.: Hospital and health facility construction under the Md. Hospital survey and plan, 40–2
  Licensing of hospitals, 113–5
  jt. auth., see Riley, R. H.

Gallie, W. Edward: Problems of practice (I. Ridgeway Trimble lecture), 315–322
Garis, Robert W.: Socialism is on the move, 453–6
Garrett County Medical Society, see Allegany-Garrett County Medical Society
Geriatrics in general practice (Johnson), 582–92
Geriatrics, Medicine's number one problem (Rusk), 331–7 (I. Ridgeway Trimble lecture)
  Selected bibliography, 337–8
  Some observations of the British system of caring for the aged and chronically ill (Riley), 465–7
Gesell developmental examinations—statewide study of premature infants (Harper), 539
Gillis, A. C., appreciation of services to library, 379, 396
Ginsberg, Milton, and Miller, Joseph M.: Abscess of the lung due to endamoeba histolytica treated by surgery and aureomycin, 295–8
Goldstein, Albert E.: Building fund committee, report, 13–5
Gorby, Brig. General Alvin L., 2nd Army surgeon, address, 565
Gould, David M.: Radiology (peptic ulcer), 61–4
Government appropriation requests of interest to the medical profession, 120
Graham, R. Walter, Jr.: Maryland advisory committee to Selective Service, a report, 8–10; Selective service, information of extreme importance!, 426
Graham, Mrs. R. Walter, Jr.: Now it's up to us, 310–11
Gray, Howard K.: The problem of jaundice in general surgery, 322–30
Greene, Margaret, to report for duty as Chief, Nursing Service, new V. A. hospital, 535
Gundry, Lewis P.: Board of medical examiners of the State of Maryland, 38
  Discussion of some of the problems associated with licensure, 167
Gundry, Mrs. Lewis P.: Woman's Auxiliary to the Medical and Chirurgical Faculty, 45–6, 116, 169–70, 206
Guttmacher, Alan F., farewell dinner, 174
Guttmacher, Manfred S.: Expert testimony from the viewpoint of psychiatry, 282–7
Gynecology, surgery, the lower midline incision (Marek), 447–52

Hamburger, Louis Philip, Finney fund committee, 106
Harford County Medical Society, 343; active members, 620
Harlan, Herbert, Memorial Fund, 603–4
Harper, Paul: Open letter on the "Statewide study of premature infants—the Gesell developmental examinations," 539
  Present status of prematures, 42–3
Health Commission, see President's commission on the health needs of the nation
Health, welfare problems, Eisenhower and Taft agree on, 610
Hearing, conservation of, in the counties of Maryland (Davens), 570–3
Hemorrhages, large, from the bowel of obscure origin (Stone), 555–8
Hepatitis, Diagnosis of chronic viral (Sborov), 92–6
Herman, N. B.: Committee on industrial health, 221
Hill-Burton hospital, construction program slowing down, 596
Hints for medical writers (Duffield), 306–7
Homologous serum jaundice, pooled plasma and (Allen), 540–7
Hopkins, H. Hanford: Capitol capsules, 221–3
  Mushroom dermatitis, 504–5
Hopkins, Mrs. H. Hanford: Annual report of the president, Woman's Auxiliary to the Baltimore City Medical Society, 357; Legislative lights, 360; Semiannual legislation report, 576
Hospital out-patient care, trends in (Stout), 354–6
Hospitals, Licensing (Fritz), 113–5
  Maryland survey and plan (Fritz), 40–2
House of delegates, Medical and Chirurgical Faculty of Maryland, annual meeting, 132–3
Howard, Ernest B.: The structure and functions of the American Medical Association, 439–43; Speaker, annual meeting, 122
Howard, John Tilden: Gastroenterology (peptic ulcer), 56–9
Howard County Medical Society, 103, 161; active members, 620
Hoxsey Cancer clinic, case of the U. S. vs., 560

Industrial medicine, expert testimony from the viewpoint of (Wolff), 195–8
Infants, premature, Present status of (Harper), 42–3
Insurance, Hospital, see Blue Cross
Insurance, Medical, see Blue Shield
Insurance, Voluntary, 266
Insurance Economics Society of America, 108

Jaundice, Problem of, in general surgery (Gray), 322–30
Jewett, Hugh J.: Blue Shield, 475
  President's report to the board of trustees, 204–5
John M. T. Finney lecture, see Medical and Chirurgical Faculty of Md., John M. T. Finney lecture
Johnson, Mrs. Marius P.: Letter to the editor, 48
Johnson, Wingate M.: Geriatrics in general practice, 582–92
Jurisprudence, Medical: Symposium on the doctor in court, 190–201, 282–295

Kantner, L. M.: Amendment to the Federal Food, Drug and Cosmetic Act, 47
  Cooperation essential, 612
  Durham-Humphrey act, 362–3
  Quackery vs. scientific medicine, 119
Kent County Medical Society, 161–62, 343; active members, 620
Kilby, Walter L., jt. auth., see Zangara, H. F.
Kerr, Mrs. James P.: Woman's Auxiliary, Montgomery County Medical Society, annual report of the president, 358
King, John Theodore, Library committee, 105
Knotts, E. Paul, "Family doctor of the year," 262
Knotts, Mrs. E. Paul: Doctor's day, 170–71
Knox, J. Hall Mason, Jr., presentation of portrait of, 580–1
Kolodner, Louis J.: Dr. Alfred Ullman, a tribute, 313
Koontz, Amos R.: Men or mice in November, 456–57
  Role of the physician as a citizen, 506–9
  Unity for a faith, 153–5
Krause, Louis A. M., Library committee, 105
  Salt, 277–281

Lemkau, Paul V.: Alcoholism, a medical and social problem, 467–73
Lewison, Edward F.: Mutiny for a bounty, 559–60
Library, 1930–50, 34–5
Library, how the, can serve the physician (Duffield), 164
Lower midline incision (Marek), 447–52
Lowry, James V.: Care, treatment and rehabilitation—narcotic drug addicts, 83–7
Lung, abscess of the, due to endamoeba histolytica treated by surgery and aureomycin (Ginsberg), 295–8

McCullough, Kendrick, jt. auth., see Waters, Zack J.
Macht, David I.: Thirty years of phytopharmacology or applications of plant physiology to medical problems, 188–190
McLanahan, Samuel, Finney Fund committee, 106
Magnuson, Paul B., Speaker, annual meeting, 122
  Too big a job for one year, 430–5 (I. Ridgeway Trimble lecture)
Marek, Charles B., and Dolce, Joseph R.: The lower midline incision, 447–52
Martin, Walter B., Speaker, annual meeting, 122
  You and your A.M.A., you are the A.M.A., 436–9
Maryland Academy of General Practice (Needle), 314
  Preliminary announcement and program, 212
Maryland Board of Medical Examiners (Gundry), 38
  Problems associated with licensure (Gundry), 167
Maryland Board of Pharmacy (Kantner), 47, 119, 362–3, 612
Maryland Civil Defense Medical Services (Riley), 10–13
Maryland Hospital Service, Inc., see Blue Cross
Maryland Medical Service, Inc., see Blue Shield
Maryland public health nurse wins Roberts fellowship, 534
Maryland Society for Medical Research (Smith), 208–9, 210
Maryland State Board of Physical Therapy Examiners: notes on physical therapy, 509–10
Maryland State Department of Health
  Monthly communicable disease report, 255, 352, 428, 474, 525, 574, 598
  Prather, Perry F., appointed Deputy State Health Director, 349–50
  Role of the, in maternity care in Maryland's counties, 522–4
  Some changes in communicable disease reporting, 253–6
Maryland State Medical Journal (Chatard), 6
  Greetings from Baltimore City Health Department (Williams), 39
  Greetings from the State Health Department (Riley), 39
  Report on (Yeager), 408
  Statement by the chairman of the council (Edwards), 7
Maryland State Nurses Association (Moubray), 118–9, 264–5
Maternity care in Maryland's counties, the role of the State Dept. of Health, 522–4
Medairy, George C.: History of the Baltimore County Medical Association (autobiography), 563–4
Medical and Chirurgical Faculty of Maryland
  Activities of (Wise), 3–6
  Annual meeting, program, 121–145
  Appointed committees, 140–5
  Building fund committee (Goldstein), 13–15
  Comments (Yeager), 49
  Committee for the study of certain phases of medical economics (Moyer), 51–2
  Committee on industrial health (Herman), 221
  Committee on rural medicine, 216
  Committee on scientific work on arrangements (Compton), 50
  Committee to cooperate with the American Medical Education Foundation (Day), 219–20
  Library
    Barker fund, 602–3
    Charles Frick reading room and the William F. Frick endowment fund, 462–63
    Disposition of book collections, 165
    Dr. Samuel Baker fund, 521
    Herbert Harlan memorial fund, 603–4
    John Fonerden, the first librarian, 520–21
    Library, 1930–1950 (Duffield), 34–5
    McCleary fund, 567
    New librarian, Miss Helen Wheeler, 602
    Stokes memorial fund, 567–8
    Osler fund, 344
    Recent additions, 252
  Members, directory, 613–42
  Message from the president (Chesney), 267
  Officers and delegates of component societies, 135–9
  Past—present—future (Chatard), 146–9
  Publications by members, 35–37, 165–166, 202–3, 568–9

- Medical and Chirurgical Faculty of Maryland, Transactions
  - Additional scientific papers presented during the April, 1952, annual meeting
    - Contraindications to ACTH and cortisone; panel discussion, 485–501
  - Advisory committee to the Woman's auxiliary, report, 422
  - American Medical Association
    - Abstract from the address of the president, John W. Cline, 399–400
    - Committees on the blood bank, 400
    - Delegates to, change in number, 398
    - Guides for conduct of physicians in relationship with institutions, 400–1
    - How the house of delegates of the A.M.A. is set up, 399
    - Medical Schools get $500,000 from, 400
    - Public relations conference, 399
    - Remarks (Yeager), 443–4
    - Report of campaign coordinating committee, 400
    - Structure and functions of the A.M.A. (Howard), 439–43
    - You are the A.M.A. (Martin), 436–9
  - Army Medical Library Committee, report, 413
  - Blood bank advisory committee, report, 419
  - Blue Shield, report by council on, 398
  - Board of Medical Examiners of Maryland, report, 401–2
  - Building plans committee, 421
  - Cancer committee, report, 411–12
  - Chairman of the committee on constitution and by-laws made ex-officio member of the Council, 397
  - Committee for the study of pelvic cancer, report, 423
  - Committee on medical research, report, 411
  - Committee on medical service and public relations, report, 415
  - Committee on the constitution and by-laws, recommended amendments to the Constitution and by-laws, 416–17
  - Committee to study certain phases of medical economics, 381, 424
  - Committee on industrial health, report, 413–14
  - Committee on maternal and child welfare, 380, 409–10
  - Committee on national emergency medical service, report, 417–9
    - American Red Cross, 418
    - Casualty clearing stations, 418
    - Funds, 419
    - Nursing institute, 418
    - Plans, 419
    - Public relations, 418
  - Committee on public instruction, report, 412–3
  - Committee on rural medicine, 380, 415–6
  - Committee on scientific work and arrangements, report, 379, 405, 408
  - Committee to advise the State Industrial Accident Commission, 414
  - Committee to consider the relationship between hospital and specialties and the manner of payment for professional services, report, 380, 423

- Medical and Chirurgical Faculty of Maryland, Transactions (Continued)
  - Committee to cooperate with American Medical Education Foundation, report, 384, 396, 425
  - Constitution and by-laws
    - Amendment to the constitution; concerning annual meeting, ratified, 382
    - Proposed amendments to the by-laws; concerning dues, 382, membership, 382, professional conduct committee, errata sheet, resolutions committee, errata, standing committees, errata; ratified, 383–4
  - Council expresses appreciation for services to Library of A. C. Gillis, 379, 396
  - Council expresses appreciation for work of George H. Yeager as Secretary and Editor, 398
  - Curator appointed, J. A. Chatard, 398
  - Delegates to the A.M.A. report, 399–401, see also M. & C. F. American Medical Association
  - Diabetic detection committee, report, 421–2
  - Directory, 1952; 613–42
  - Eugene Fauntleroy Cordell fund committee, 411
  - Election of officers for 1953, 383
  - Emeritus members added, 1952, 397, 398
  - Federal Dept. of Health, resolution on creation of, 384; correction on errata sheet
  - Fifty year member, Dr. Otto Schaefer, 397
  - Finance committee (new building), 420
  - General practitioners and specialists, distribution of, in areas needed, resolution, 385
  - Geriatrics committee, resolution, 385
  - House of Delegates, 198th meeting, special session, 378; 199th, first session, 381; 200th, second session, 382; 201st, third session, 383
  - I. Ridgeway Trimble lectures
    - Geriatrics in general practice (Johnson), 582–92
    - Medicine's number one problem (Rusk), 331
    - Problems of practice (Gallie), 315
    - Too big a job for one year (Magnuson), 430
  - John M. T. Finney lecture
    - Problem of jaundice in general surgery (Gray), 322–30
  - Joint committee with the Bar Association on medicolegal problems, 424–5
  - Joint medical legal committee of the Bar Association and the Faculty proposed by Council, 397
  - Legislative committee, report, 411
  - Library committee, report, 402; statistical report for 1951, 402–5
  - Maryland State Medical Journal, report on (Yeager), 408
  - Medical Care campaign committee, 419
  - Memoir committee, report, 410
  - Mental Hygiene committee, report, 415
  - Nominations, 1953; 133, 382
  - Physicians defense, report, 398
  - Physiotherapy committee, report, 414
  - Postgraduate educational committee, report, 421

Medical and Chirurgical Faculty of Maryland, Transactions (Continued)
  Presidential addresses
    Medical education and medical research are part and parcel of the medical profession (Chesney), 369
    Midcentury challenge (Pearre), 16 (reprint, 1950)
  Presentation of the portrait of J. Hall Mason Knox, Jr., 580–1
  Professional conduct committee, report, 408
  Reference committee, suggested, 397
  Scientific speakers bureau, report, 422
  Secretary's report, 379, 386, 387
  Semiannual meeting, expense to be borne in part by Faculty, 397
  Semiannual meeting, 1951, program, 406–7
  Semiannual meeting, 1952, announcement, 426
  Sesquicentennial committee (new building), 420
  Speakers Bureau of the Medical Care Campaign committee, 420
  State practice act, 402
  Tax evasion cases, Council action, 398
  Treasurer's report, 386; financial statement, 388–96
  Tuberculosis committee, 380, 414–15
    Rescinding former action on Tuberculosis committee recommendation, 381
  William Royal Stokes Memorial Fund lecture
    Physician against atomic attack (Wilson), 182–6
  Williams, William F., appointed vice-president in place of N. A. Gracie, deceased, 398
  Woman's auxiliary, denied use of Faculty seal, 397
Medical care, Maryland county program—a progress report (Notkin), 268–71
Medical Education Foundation, see American Medical Education Foundation
Medical reprints, cost of (Lewison), 559–60
Medical schools, get $500,000 from A.M.A., 400
Medical student preceptorship, 453
Medicine's number one problem (Rusk), 331–7
Medicolegal symposium—drug addiction—21–7, 78–91
Mellinkoff, Sherman M.: Internal medicine (peptic ulcer), 54–6
Men or mice in November? (Koontz), 456–7
Military service, aid to doctors discharged from, 519
Miller, J. M., jt. auth., see Ginsberg, Milton
Montgomery County Medical Society, 32–3, 103, 251; active members, 620–23
Moubray, M. Ruth: Better education needed for nurses, 611–2
  Financial aid to student nurses, 265
  Maryland Licensed Practical Nurses Association, 264
  Maryland State Nurses Association, 118–9
  Purpose of Red Cross Volunteer Nurse's Aide program, 479–80
  Working conferences: analysis of activities of the head nurse, 363–64
Moyers, Waldo B.: Private or government control of the practice of medicine (Committee for the study of certain phases of medical economics), 51–2
Murray-Dingell bills for hospitalization at age 65, 314
Mushroom dermatitis (Hopkins), 504–5

Narcotic drug addicts, care, treatment and rehabilitation (Lowry), 83–7
National League for Nursing, 480
National Science Foundation, medical research fellowships offered by, 569
Needle, Nathan E.: Maryland Academy of General Practice, 314
Newell, Mrs. Pauline, see Stout, Merrell L.
Non-resident members, Medical and Chirurgical Faculty of Md., 626
Notkin, Herbert: Maryland County Medical Care Program—a progress report, 268
Nurses, Army announces program to ease shortage of, 519
  Auxiliary and nurse recruitment (Robinson), 260
  Better education needed for (Moubray), 611–2
  Maryland State Nurses Association (Moubray), 118–19
  Student nurse recruitment (Courtney), 118
  Student Nurses Council of Md. (Williams), 265
  Working conferences: analysis of activities of the head nurse (Moubray), 363–64
Nursing service staffing for new V. A. Hospital in Baltimore, 534–5

Obstetrical and Gynecological Society of Maryland, 29
Oregon Medical Society, Supreme Court rules in favor of, 340
Osler fund, 344

Parris, Albion K.: Maryland Hospital Service, Inc., 308
Past—present—future (Chatard), 146
Pathologists, Clinical in Md., 365–6
Pearre, A. Austin: Midcentury challenge, 16–20
  Library committee, 105
Pearre, Mrs. A. Austin: Annual report of the president, Frederick Co. Woman's Auxiliary, 357–8
Peptic ulcer, Panel discussion, 53–74
  Selected bibliography, 74–77
Physical therapy; bibliography, 510–512; notes on, 509–10
Physician against atomic attack (Wilson), 182–6
Physician as a citizen (Koontz), 506–9
Physicians, public relations, No longer our ivory towers (Day), 180–1
Plant physiology, applications of, to medical problems (Macht), 188–90
Plasma, pooled, and homologous serum jaundice (Allen), 540–7
Poliomyelitis, relationship between inoculations and (Riley), 350–1
Prather, Perry F., appointed Deputy State Health Director, 349–50

Premature infants, statewide study of (Harper), 539
President's Commission on the health needs of the nation
  Too big a job for one year (Magnuson), 430–5
  Witnesses urge more funds, services and facilities, 566
Prince George's County Medical Society, 30, 103, 251, 519, 601, active members, 623–4
Problems of practice (Gallie), 315–22
Publications by Faculty members, 35–7, 165–6, 202–3, 345–6, 568–9

Quackery vs. scientific medicine (Kantner), 119
Queen Anne's County Medical Society, 103, active members, 624

Rhoads, Cornelius, speaker, annual meeting, 122
Rice, Anne, wins Roberts fellowship, 534
Rienhoff, William F., Jr.: Surgery (Thyroid), 226–7
Riley, Robert H., and Fritz, H. G.: Maryland Civil defense medical services, 10–13
Riley, Robert H.: Relation between inoculations and poliomyelitis, 350–1
  Some observations of the British system of caring for the aged and chronically ill, 465–7
Roberts Fellowship award won by Md. public health nurse, 534
Robinson, Mrs. Harry M. Jr.: The Auxiliary and nurse recruitment, 260–1
Rusk, Howard A.: Medicine's number one problem, 331–7 (I. Ridgeway Trimble Fund Lecture)
Radiology, peptic ulcer (Gould), 61–4
Red Cross Volunteer Nurse's Aide program (Moubray), 479–80
Reed-Keogh Bills, 252
Research council for Economic Security: Voluntary insurance, 266
Rose, Edward, moderator, Panel discussion—thyroid, 224–41

Saint Mary's County Medical Society, 162, 460, 564, active members, 624
Salt (Krause), 277–81
Sborov, Victor M.: Diagnosis of chronic vital hepatitis, 92–6
Schaefer, Otto, fifty year member, Medical and Chirurgical Faculty, 397
Second Army surgeon, name and address, 565
Selective service, information of extreme importance, 426
  Maryland advisory committee (Graham), 8–10
  Physicians, Priority I, urged to join reserves, 209
Seymour, William S., honored by Talbot County Medical Society, 30–2
Sherbow, Joseph: Judicial administration of violations (drug addiction), 78–83
Smith, Dietrich C.: Maryland Society for Medical Research, 210
  Program of the Maryland Society for Medical Research, 208–9
Smith, W. Conwell: Expert testimony from the viewpoint of the jurist, 288–291
Socialism is on the move (Garis), 453–6
Sodaro, Anselm: Prosecution of drug cases, 25–7
Somerset County Medical Society, active members, 624
Somerville, Donald L.: Baltimore County Medical Society, 301–2
Sprecher, Mrs. Omar D., Jr.: Doctor's wives, be informed!, 208
Stone, Douglas H., Finney fund committee, 106
Stone, Harvey B.: Large hemorrhages from the bowel of obscure origin, 555–8
Stone, Harvey B., moderator, Panel discussion: peptic ulcer, 53–74
Stout, Merrell L., and Newell, Mrs. Pauline: Trends in hospital out-patient care, 354–6
Strobel, Mrs. Martin E.: Annual report of the president, Baltimore County Woman's Auxiliary, 357
Sugar, Mrs. S. Jack: Annual report of the president, Prince George's County Woman's Auxiliary, 358–9

Talbot County Medical Society, 30–2, 104, active members, 624
Tax relief petition, 174
Telepaque, cholecystography using (Zangara), 593–6
Thirty years of phytopharmacology or applications of plant physiology to medical problems (Macht), 188–90
Thomas, Henry Malcolm, Jr., Finney fund committee, 106
Thomas, Nathaniel R., jt. auth., see Waters, Zack J.
Thomsen, Roszel C.: Problems presented to the youth of the community by the traffic in drugs, 87–9
Thyroid, lingual (Waters), 241–47
Thyroid, panel discussion, Baltimore City Medical Society, 224–41: Internal medicine (Carey), 228–30
  Pathology (Berthrong), 231–2
  Psychiatry (Dixon), 225–6; Radioactive iodine (Asper), 233–234; Surgery (Rienhoff), 226–8
Thyroid, selected bibliography, 248–9
Timonium Fair Health Booth, 1952, 531–2
Traumatic surgery, expert testimony from the viewpoint of (Eaton), 199–201
Trial counsel, expert testimony from the viewpoint of (Coughlan), 191–195
Trimble lecture, see Medical and Chirurgical Faculty of Md. I. Ridgeway Trimble lectureship
Tuberculosis, policies in Baltimore County; report of the executive committee meeting of the Baltimore County Medical Society, 562

Ullman, Alfred—a tribute (Kolodner), 313
U. S. Army, announces program to ease shortage of nurses, 519
U. S. Public Health Service, doctors lose military status, 575
U. S. vs. Hoxsey Cancer Clinic, 560
Unity for a faith (Koontz), 153–5

Universal military training, medical student deferment, 112
University of Maryland, course in the basic sciences as they apply to the practice of medicine, 427

Vaccinations for international travel, 266
Veteran physicians of World War II, 453
Veterans Administrations Hospital, Baltimore, see Baltimore. Veterans Administration Hospital

Washington County Medical Society, 32, 104, 162, 302, 601, active members, 624–5
Waters, Theodore C., chairman, medicolegal symposium, drug addiction, 21–7, 78–91
Waters, Zack J.: Lingual thyroid, 241–247
Webster, Mrs. Thomas: Getting out the vote, 608–9
Wells, Mrs. S. Robert: Washington County Woman's Auxiliary annual report to the president, 539–60
Wharton, Lawrence Richardson, Library committee, 105
Wheeler, Helen, new librarian, Medical and Chirurgical Faculty Library, 602
Whitridge, John, Jr.: Maternity care in Maryland's counties —the role of the State Dept. of Health, 522–4
Wicomico County Medical Society, 104, active members, 625–6
Williams, Charles H.: Letter to the editor, 173
Williams, Mrs. Charles Herman, president Woman's Auxiliary: Auxiliary convention notes, 528–30; photograph, 527; president's message, 527–8
Williams, Huntington: New communicable disease chart, 109
Williams, Joan: Student Nurses Council of Maryland, 265
Williams, Robert P., Brig. Gen.: Casualty clearing stations, 107
  Civil defense, Maryland, 347–8
Wilson, William L.: The physician against atomic attack, 182–6
Winslow, Randolph, 604
Wise, Walter D.: Activities of the Medical and Chirurgical Faculty, 3–6
  Moderator: Symposium on the doctor in court, 190–201, 282–95
Wolff, Mrs. Eldridge H.: "Today's health," 261
Wolff, Thomas Conrad: Expert testimony from the viewpoint of industrial medicine, 195–8
Wollenweber, Henry L.: Clinical pathology in Maryland, 365–6
Wolman, Samuel, Library committee, 105
Woman's Auxiliary to the Medical and Chirurgical Faculty of Maryland (Gundry), 45–6, 116, 169, 170, 206–7
  Annual meeting, 3rd, tentative program, 169–70, 206
  Are you registered to vote? (Chalfant), 361
  Auxiliary news, 360–1, 530–2, 577, 609–10
  Chicago conference, Woman's Auxiliary to the A.M.A., 45–6
  Civil defense program (Baumgartner), 116–7
Woman's Auxiliary to the Medical and Chirurgical Faculty of Maryland (Gundry), (Continued)
  Component auxiliaries
    Annual reports from presidents of, 357–60
      Baltimore City (Hopkins), 357
      Baltimore County (Strobel), 357
      Frederick County (Pearre), 357–8
      Montgomery County (Kerr), 358
      Prince George's County (Sugar), 358–9
      Washington County (Wells), 359–60
    Election of officers, Baltimore City, 262, Washington County, 263
    News, 45–6, 116, 170, 262–3
  Creative Arts Show (Compton), 171
  Doctor's Day, 1952; (Knotts), 170–1; proclaimed, 261–2
  Doctors' wives, be informed! (Sprecher), 208
  Faculty seal, denied use of, 397
  General meeting, 606–7
  Getting out the vote (Webster), 608–9
  Legislation report, semiannual (Hopkins), 576
  Legislative lights (Hopkins), 360
  Medical research: Now it's up to us (Graham), 310–11
  Nurse recruitment and the Auxiliary (Robinson), 260
  Nursing scholarships, 208
  Open letter to the (Day), 530
  President's message (Williams), 527–8
  President, New, word from (Williams), 309
  President, Outgoing, remarks from (Yeager), 311–2
  Program (Ball), 476
  Public relations, good (Chalfant), 207
  Resolutions, 309–10
    Concerning closer medical supervision of mentally or physically impaired drivers, 309
    On Americanism, particularly in education, 310
  Semiannual meeting, 1951, program, 407
  Semiannual meeting, 1952, announcement, 427
  "Today's Health" (Wolff), 261
  What about our American education? (Chalfant), 607–8
Woodward, Theodore E.: Status of chloramphenicol therapy, 537–8
Worcester County Medical Society, 162, active members, 626
Writers, medical, hints for (Duffield), 306

Yeager, George H.: Comments, 49
  Editorial—Transactions, 367
  Foreword, 1–2
  Appreciation of work as Secretary and Editor of the *Md. State Medical Journal*, 398
Yeager, Mrs. George H.: Woman's Auxiliary to the Medical and Chirurgical Faculty, 309–10

Zangara, Henry F., Davidson, Charles N., and Kilby, Walter L.: Cholecystography using telepaque, 593–6

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in a variety of forms, including:

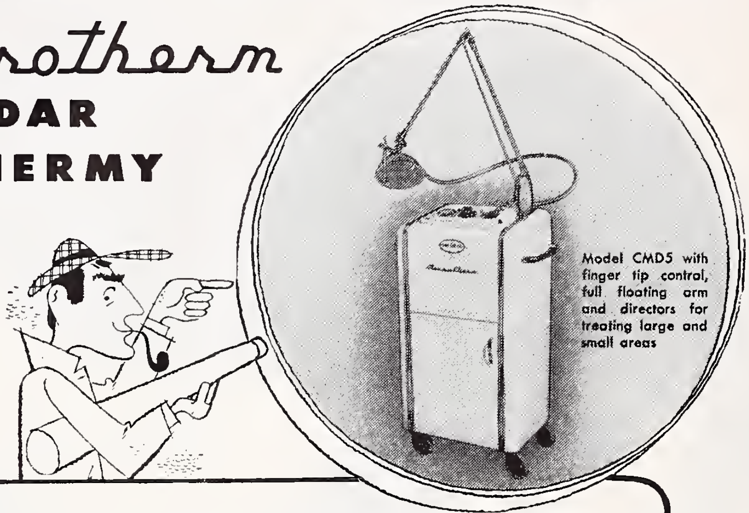
CHLOROMYCETIN Kapseals,® 250 mg., bottles of 16 and 100.
CHLOROMYCETIN Capsules, 100 mg., bottles of 25 and 100.
CHLOROMYCETIN Capsules, 50 mg., bottles of 25 and 100.
CHLOROMYCETIN Ophthalmic Ointment, 1%, ⅛-ounce collapsible tubes.
CHLOROMYCETIN Ophthalmic, 25 mg. dry powder for solution, individual vials with droppers.

MEDICAMENTA VERA
PD & CO.

Parke, Davis & Company
DETROIT, MICHIGAN

BEFORE YOU INVEST in Diathermy Equipment
INVESTIGATE Raytheon's Up-To-The-Minute

Microtherm
RADAR
DIATHERMY



Model CMD5 with finger tip control, full floating arm and directors for treating large and small areas

Here are some of the outstanding features of Raytheon Microwave Diathermy

1. No television interference. *Microtherm* employs the "radar" wave length — way above the TV wave length.
2. A high degree of absorption
3. Penetrating energy producing deep heating
4. A desirable temperature ratio of fat to vascular tissue
5. Effective production of active hyperemia
6. Desirable relationship between cutaneous and muscle temperature
7. Controlled application over large and small areas — 3 directors provide central or peripheral heat and precisely radiating areas as small as 3 or as large as 150 square inches — a finger tip control Dazor floating arm assures maximum flexibility
8. Elimination of electrodes, pads and danger of arcs
9. No contact between patient and directors

Are you willing to be shown? Ask us to demonstrate the Microtherm

A. J. BUCK & SON

SURGICAL INSTRUMENTS—HOSPITAL
SUPPLIES AND MEDICAL EQUIPMENT

1515 E. NORTH AVE.
BALTIMORE 13, MD. • SA. 6640

MARYLAND
STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

1211 Cathedral Street, Baltimore 1, Maryland

Official Publication of the Medical and Chirurgical Faculty of the State of Maryland

VOLUME 2 *January, 1953* NUMBER 1

CONTENTS

Editorial

A Word of Appreciation To Our Editor 1

To Mr. Charles P. McCormick 2

Scientific Papers

The Recent Advances in Surgery of the Autonomic Nervous System ...... Osler A. Abbott, M.D. 3

The Relative Position of the Specialist, the General Practitioner, and the Public Health Officer in Britain .... Sir Allen Daley, M.D. 24

Clinical Pathological Conference .... T. Nelson Carey, M.D., C. Gardner Warner, M.D. 33

Component Medical Societies

Anne Arundel County .... George C. Basil, M.D. 38

Calvert County .... Page C. Jett, M.D. 38

Dorchester County .... Walter B. Johnson, M.D. 38

Queen Anne's County .... C. Rodney Layton, M.D. 38

Washington County .... E. F. Poole, M.D. 39

Baltimore City Medical Society Program 39

Library

The Walter Ralph Steiner Memorial Collection 40

Recent Publications by Faculty Members 42

Health Department

State Department of Health 45

Monthly Communicable Disease Report 50

Blue Cross and Blue Shield

Blue Cross and the Nation .... Reginald H. Dabney 51

Woman's Auxiliary to the Medical and Chirurgical Faculty .... Mrs. George H. Yeager 52

Index 1952 Journal—pages 643–652
For Inclusion in Vol. I.

Copyright 1953 by the Medical and Chirurgical Faculty of the State of Maryland

THE MARYLAND STATE MEDICAL JOURNAL

Editorial and Business Office, 1211 Cathedral Street, Baltimore 1, Maryland

EDITOR
George H. Yeager

EDITORIAL BOARD
Hugh J. Jewett   Emil Novak   John A. Wagner   A. Earl Walker
J. Tyler Baker   Leslie E. Daugherty

Business Manager: Mr. Walter N. Kirkman

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

OFFICERS FOR 1953

President: Maurice C. Pincoffs
Treasurer: J. Albert Chatard
Secretary: George H. Yeager
Assistant Secretary: Everett S. Diggs
Vice-Presidents: George O. Eaton
Osborne D. Christensen
William F. Williams

COUNCILORS

Baltimore City
C. Reid Edwards, *Chairman*—1953
E. Cowles Andrus, *Vice-Chairman*—1954
Charles R. Austrian—1955
Monte Edwards—1954
Warfield M. Firor—1954
Whitmer B. Firor—1954
Hugh J. Jewett—1955
Walter D. Wise—1955

Eastern Shore
William B. Long—1955
William D. Noble—1954

Western Shore
O. H. Binkley—1953
Thomas A. Christensen—1954
James T. Marsh—1953
W. O. McLane—1953
Palmer F. C. Williams—1954

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegate
Warde B. Allan—1954
John W. Parsons—1953

Alternate
Louis H. Douglass—1954
Benjamin S. Rich—1953

Owned and Published Monthly by

THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

Secretary's Office, 1211 Cathedral Street, Baltimore, Maryland

Copyright 1953, The Medical and Chirurgical Faculty of the State of Maryland

1211 Cathedral Street, Baltimore, Maryland
Entered as second-class matter at the Post Office at Baltimore, Md.

Single Copies, 50¢ ***Subscription $3.00 per year***

MANUSCRIPTS: Manuscripts should be typewritten, double spaced, on white paper 8½ x 11 inches. The original copy, with one carbon copy, should be submitted. Carbon copies or single-spaced manuscripts will not be considered.

Footnotes, bibliographies and legends should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodicals with volume, page, and year.

Used manuscripts will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

NEWS: Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

ADVERTISEMENTS: All advertising copy of products approved by the Councils of the American Medical Association shall be acceptable for publication, together with advertising copy of products exempted by these same Councils, provided such copy does not present a product in a false and/or misleading light. Such other advertising copy may be accepted, subject to the approval of The Editorial Board. All copy must reach the JOURNAL office by the first day of the month preceding publication.

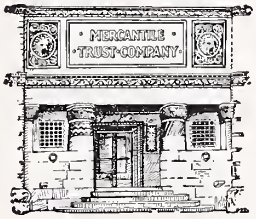
SUBSCRIPTIONS: Membership in the Medical and Chirurgical Faculty of the State of Maryland includes subscription to the JOURNAL. Additional copies may be secured from the Editor.

Busy Doctors Need Financial First Aid

The more successful a physician becomes, the less time he can spare to manage his financial business. Many a prominent doctor feels the need of financial first aid, followed by permanent assistance.

Permit us to recommend a confidential talk with one of our officers, who will be happy to advise you on steps indicated by your financial condition.

Uptown or Downtown, The Mercantile has many services of practical advantage to busy doctors, dentists and other professional men and women.



At your request, an experienced representative will call on you any hour of the day or evening, to explain the Mercantile services.

MERCANTILE TRUST COMPANY

OF BALTIMORE

Chartered 1884

DOWNTOWN
Baltimore, Calvert and Redwood Streets

UPTOWN
Charles and Chase Streets

"PREMARIN"®

Highly effective • Well tolerated • Imparts a feeling of well-being

"PREMARIN"

The menopausal patient
welcomes the sense of well-being
imparted by "Premarin."

"PREMARIN"

Estrogenic Substances (water-soluble)

"PREMARIN"

also known as Conjugated Estrogens (equine)

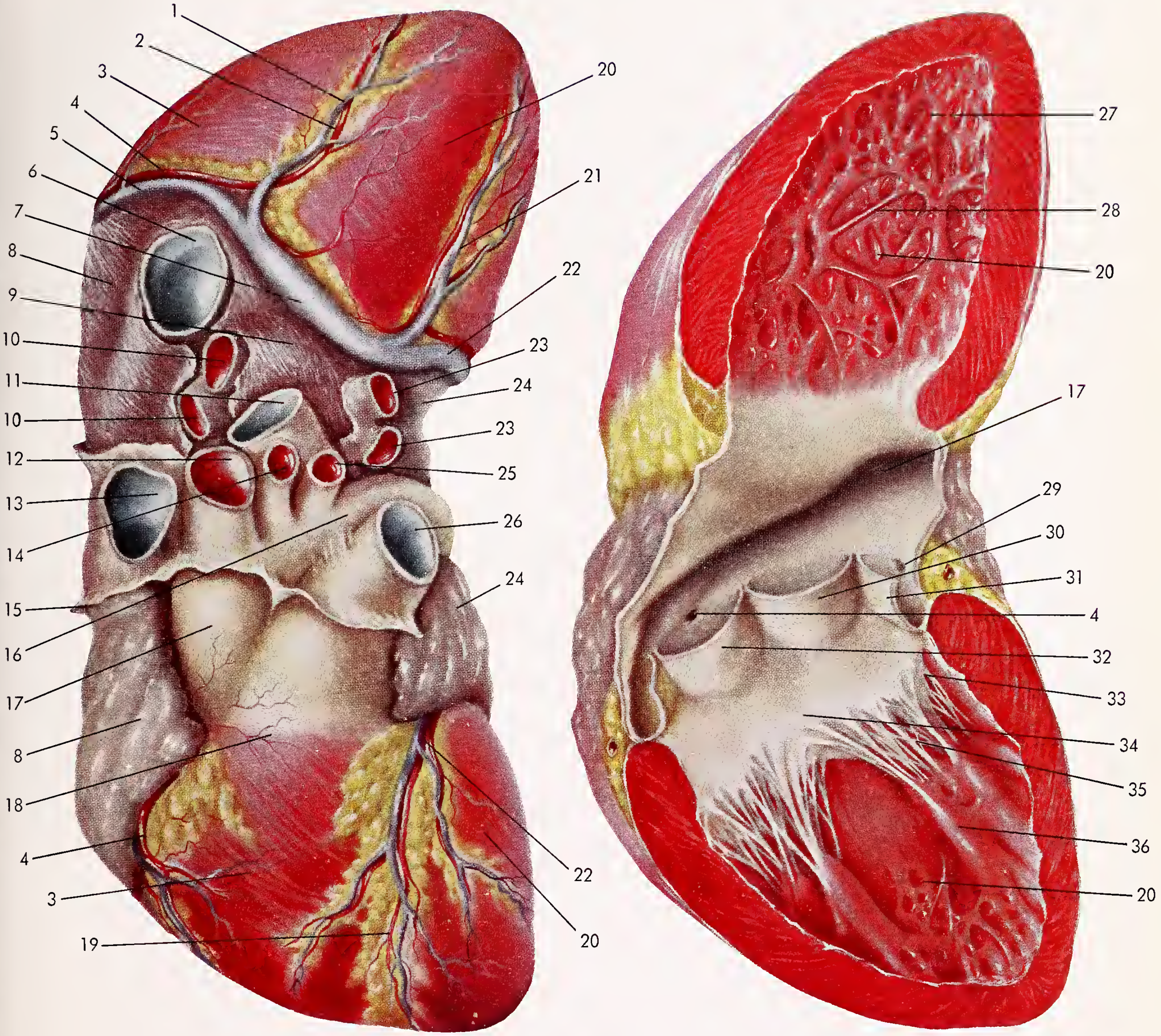
"PREMARIN"

5209

Ayerst®

AYERST, McKENNA & HARRISON Limited • New York, N. Y. • Montreal, Canada

Anatomy *of the* Heart



1 Middle cardiac vein
2 Posterior descending branch of right coronary artery
3 Right ventricle
4 Right coronary artery
5 Small cardiac vein
6 Inferior vena cava
7 Coronary sinus
8 Right auricle
9 Left atrium
10 Right pulmonary vein
11 Right branch of pulmonary artery
12 Innominate artery
13 Superior vena cava
14 Left common carotid artery
15 Pericardium
16 Aortic arch
17 Ascending aorta
18 Conus arteriosus
19 Anterior descending branch of left coronary artery
20 Left ventricle
21 Posterior vein of left ventricle
22 Great cardiac vein
23 Left pulmonary vein
24 Left auricle
25 Left subclavian artery
26 Left branch of pulmonary artery
27 Trabeculae carneae
28 Trabecula tendinea
29 Left coronary artery
30 Posterior semilunar valve
31 Left semilunar valve
32 Right semilunar valve
33 Posterior cusp of mitral (bicuspid) valve
34 Anterior cusp of mitral (bicuspid) valve
35 Chordae tendineae
36 Papillary muscle

This is one of a series of paintings by Paul Peck, illustrating the anatomy of various organs and tissues of the body which are frequently attacked by infection, where aureomycin may prove useful.

Aureomycin

HYDROCHLORIDE CRYSTALLINE

in

Infections Involving the Heart

ENDOCARDITIS—Aureomycin has established itself as one of the most valuable agents available for the treatment of infections involving the heart. Aureomycin is now recognized as a highly effective antibiotic against the organisms most frequently encountered in endocarditis—staphylococci, *Str. viridans*, *Str. fecalis* and other enterococci. These organisms are being increasingly found resistant to penicillin and streptomycin. Endocarditis caused by these organisms has responded to aureomycin after failure of other antibiotics. Aureomycin is held by many physicians to be an antibiotic of choice for prophylactic use in patients with organic cardiac disease who require oral, intestinal, or rectal surgery, or any transurethral operative procedure. Endocarditis complicating typhus and brucellosis has responded well to aureomycin therapy.

PERICARDITIS—The importance of aureomycin in pericarditis has been demonstrated by its successful use after failure of other therapy—in acute nonspecific pericarditis, possibly of viral etiology; *H. influenzae* pericarditis; tularemic pericarditis; and actinomycotic pericarditis.

RHEUMATIC FEVER—Because aureomycin is an antibiotic with a wide range of effectiveness against the pathogenic strains of streptococci, its use has been recommended for the prevention of acute rheumatic fever and its cardiac complications.

* * *

PACKAGES: *Capsules:* 50 mg.–Vials of 25 and 100; 100 mg.–Vials of 25 and bottles of 100; 250 mg.–Vials of 16 and bottles of 100. *Ophthalmic Solution:* Vials of 25 mg.; solution prepared by adding 5 cc. distilled water.

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
30 ROCKEFELLER PLAZA, NEW YORK 20, N.Y.

A bibliography of 39 selected references will be mailed on request.

still winning new friends

right through the menopause

on oral estrogen therapy that imparts no odor or after-odor, no taste or after-taste

Sulestrex®

piperazine tablets

(PIPERAZINE ESTRONE SULFATE, ABBOTT)

YOUR prudent and assuring explanations will help—clearing away the jungle of her doubts and fears. Then SULESTREX will help—in controlling the physical symptoms of the climacteric.

Years of search have given you SULESTREX—an odorless, absolutely pure, crystalline estrogen, chemically standardized for unvarying hormonal activity. Unexcelled—therapeutically *and* esthetically—these tiny uncoated tablets will never insult the breath or perspiration, never annoy with "after-taste."

A new report by Reich and associates[1] confirms and extends his conclusions from his pilot study[2] . . .

"*Piperazine estrone sulfate* (SULESTREX) *is a clinically effective oral estrogenic substance, easy to administer and extremely well tolerated. Its action is accompanied with an amazingly low incidence of side reactions.*"

175 patients were included in this latest study, 50 of whom received therapy to relieve postpartum breast engorgement.

Make your own test—on your next menopausal patient. One trial will give impressive argument for this newest advance in oral estrogen therapy. SULESTREX is available in 0.75-, 1.5-, and 3-mg. grooved tablets. Abbott

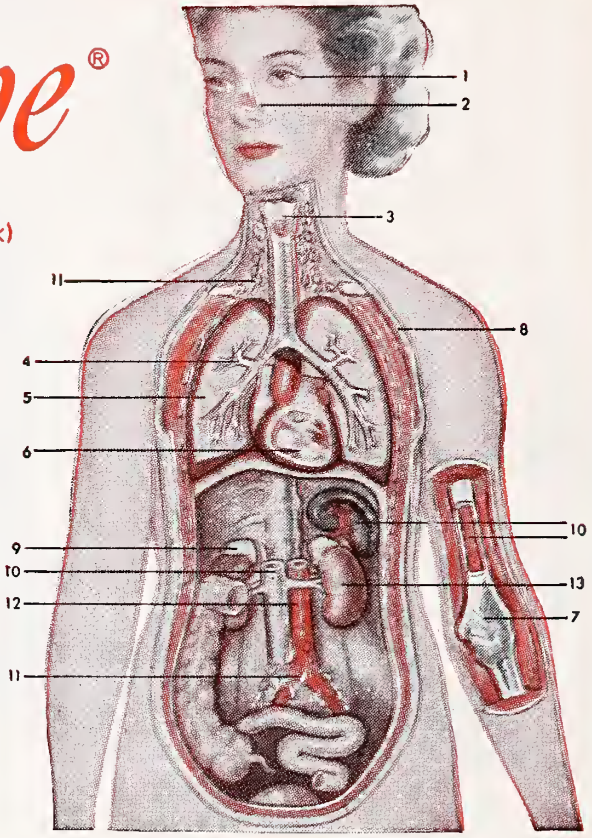
[1] Reich, W. J., et al. (1952), A Recent Advance in Estrogen Therapy. II. Amer. J. Obst. & Gynec., 64:174, July. [2] Reich, W. J., et al. (1951), A Recent Advance in Estrogen Therapy. I. Amer. J. Obst. & Gynec., 62:427, August. 1-81

Cortone®

ACETATE

(CORTISONE ACETATE, MERCK)

The many indications for CORTONE *highlight its therapeutic importance in everyday practice*



Primary Site of Pathology and Indications

1. EYE—Inflammatory eye disease. **2. NOSE**—Intractable hay fever. **3. LARYNX**—Laryngeal edema (allergic). **4. BRONCHI**—Intractable bronchial asthma. **5. LUNG**—Sarcoidosis. **6. HEART**—Acute rheumatic fever with carditis. **7. BONES AND JOINTS**—Rheumatoid arthritis; Rheumatoid spondylitis; Acute gouty arthritis; Still's Disease; Psoriatic arthritis. **8. SKIN AND CONNECTIVE TISSUE**—Pemphigus; Exfoliative dermatitis; Atopic dermatitis; Disseminated lupus erythematosus; Scleroderma (early); Dermatomyositis; Poison Ivy. **9. ADRENAL GLAND**—Congenital adrenal hyperplasia; Addison's Disease; Adrenalectomy for hypertension, Cushing's Syndrome, and neoplastic diseases. **10. BLOOD, BONE MARROW, AND SPLEEN**—Allergic purpura; Acute leukemia† (lymphocytic or granulocytic); Chronic lymphatic leukemia.† **11. LYMPH NODES**—Lymphosarcoma†; Hodgkin's Disease†. **12. ARTERIES AND CONNECTIVE TISSUE**—Periarteritis nodosa (early). **13. KIDNEY**—Nephrotic Syndrome, without uremia (to induce withdrawal diuresis). **14. VARIOUS TISSUES**—Sarcoidosis; Angioneurotic edema; Drug sensitization; Serum sickness; Waterhouse-Friderichsen Syndrome.

†Transient beneficial effects.

CORTONE *is the registered trade-mark of Merck & Co., Inc. for its brand of cortisone.*

MERCK

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY

Upjohn

less-antigenic penicillin:

Cer-O-Cillin

Trademark Reg. U. S. Pat. Off.

POTASSIUM

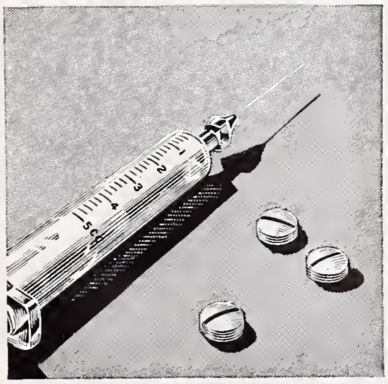
ACCEPTED
COUNCIL ON
PHARMACY
AND
CHEMISTRY
AMERICAN MEDICAL ASSOCIATION

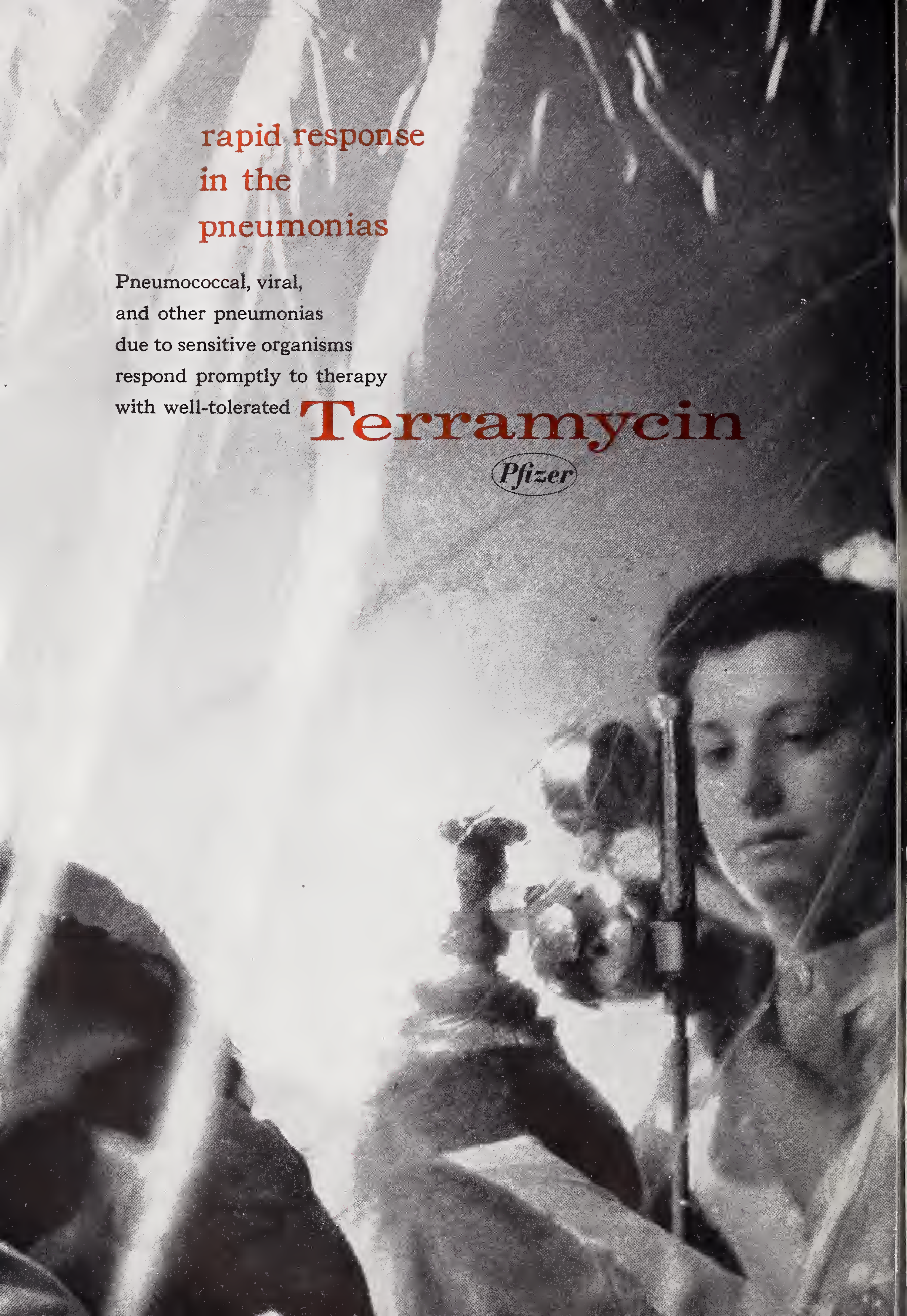
Available as:

Sterile vials containing 200,000 units Crystalline Penicillin O Potassium

Bottles of 12 buffered tablets, each containing 100,000 units Crystalline Penicillin O Potassium

The Upjohn Company, Kalamazoo, Michigan





rapid response
in the
pneumonias

Pneumococcal, viral,
and other pneumonias
due to sensitive organisms
respond promptly to therapy
with well-tolerated **Terramycin**

Pfizer

The Beautiful Park Plaza

features Maryland's most distinguished

dining and cocktail facilities...

THE PREAKNESS ROOM

THE PUB ROOM

THE CLUB BAR

The finest foods obtainable, painstakingly prepared and courteously served . . . to a discriminating clientele.

PARK PLAZA HOTEL

CHARLES AT MADISON

LUNCHEONS DINNERS BANQUETS

VErnon 4000

Salt is what makes things taste bad when it isn't in them.*

Most people find foods unappealing and insipid without salt. Therefore, when salt restriction is indicated, the patient must be impressed with the importance of a salt-free diet and must adhere faithfully to a rigid regimen. "With the development of such preparations as Neocurtasal . . . the problem of palatability and a salty taste has been fairly well solved . . ."[1]

Neocurtasal®

" . . . trustworthy nonsodium-containing salt substitute"[2]

—lends the desired salty flavor to foodstuffs, and can be used in all salt-free and low sodium diets.

CONSTITUENTS: Potassium chloride, ammonium chloride, potassium formate, calcium formate, magnesium citrate and starch.

and

NEOCURTASAL

Iodized

(contains
potassium iodide 0.01%)

Neocurtasal, trademark reg. U. S. & Canada.

Neocurtasal looks and pours like table salt and may be used in the same manner.

Both available in 2 oz. shakers and 8 oz. bottles.

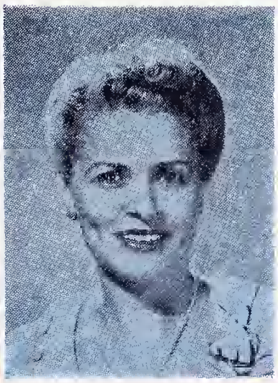
Winthrop-Stearns INC.
NEW YORK 18, N. Y. WINDSOR, ONT.

---

1. Merryman, M. P.: The Use of the Low Sodium Diet. *South Dakota Jour. Med. & Pharm.*, 2:57, Feb., 1949.
2. Heller, E. M.: The Treatment of Essential Hypertension. *Canad. Med. Assn. Jour.*, 61:293, Sept., 1949.

*Author unidentified. From Mencken, H. L.: A New Dictionary of Quotations. New York, Alfred A. Knopf, 1942, p. 1057.

"particularly useful...
for the routine therapy
of the
menopause"[1]



ESTINYL

ESTINYL® Tablets alleviate menopausal symptoms rapidly and smoothly in very small doses. A derivative of estradiol, ESTINYL (ethinyl estradiol) produces the sense of well-being characteristic of therapy with natural estrogens.

Tablets of 0.02, 0.05, and 0.5 mg.

[1] Perloff, W. M.: Am. J. Obst. & Gynec. 58:684, 1949.

Schering CORPORATION
BLOOMFIELD, N. J.

ESTINYL

the new

WELL-TOLERATED

wide-range antibiotic

'Ilotycin' is a powerful antibacterial of proved effectiveness* in the treatment of infections due to:

ORGANISMS	INFECTIONS
1. Staphylococci	Bacteremia, meningitis, pneumonia, osteomyelitis
2. Hemolytic streptococci	Cellulitis, erysipelas, peritonsillar abscess, pharyngitis, pneumonia, scarlet fever, septic sore throat, tonsillitis, wound infections
3. Pneumococci	Empyema, lobar pneumonia
4. Corynebacterium diphtheriae	Diphtheria carriers
5. Nonhemolytic streptococci	Some cases of endocarditis, genito-urinary tract infections

*References

1. Heilman, F. R., Herrell, W. E., Wellman, W. E., and Geraci, J. E.: Some Laboratory and Clinical Observations on a New Antibiotic, Erythromycin ('Ilotycin'), Proc. Staff Meet., Mayo Clin., *27*:285 (July 16), 1952. 2. Haight, T. H., and Finland, M.: Laboratory and Clinical Studies on Erythromycin, New England J. Med., *247*:227 (August 14), 1952. 3. Smith, J. W., Dyke, R. W., and Griffith, R. S.: Erythromycin: Studies on Absorption Following Oral Administration and on Treatment of 33 Patients, to be published. 4. Spink, W. W.: Personal communications. 5. Romansky, M. J.: Personal communications.

Lilly

ILOTYCIN

(ERYTHROMYCIN, LILLY)

DOSAGE: Adults—Total daily doses of 400 to 2,000 mg. are recommended, depending on the type and severity of the infection. Lobar pneumonia, bronchopneumonia, and some of the milder types of respiratory infections caused by organisms susceptible to 'Ilotycin' have consistently responded to doses of 100 mg. every four to six hours. For other infections, larger doses of 300 to 500 mg. every six to eight hours should be employed.
Children—6 to 8 mg. per Kg. of body weight every six hours. Therapy should be continued for at least forty-eight hours after the temperature has returned to normal and acute symptoms have subsided.
Available in 100-mg. specially coated tablets in bottles of 36.

Maryland
STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 2 *January, 1953* NUMBER 1

EDITORIAL

A WORD OF APPRECIATION TO OUR EDITOR

I wish, as my last official act, to express on behalf of the members of the Faculty our deep appreciation of the services rendered by Dr. Yeager as Editor of the Maryland State Medical Journal during the year which comes to a close tonight.

During these past twelve months he not only participated in the birth of our Journal, he also saw it safely through its period of infancy and has soundly planned for the second year of its life. Who can doubt that this lusty child will grow apace and live to be a credit to its combined obstetrician-pediatrician-nurse, as well as to its parents?

To Dr. Yeager more than to anyone else is due the credit for placing the Journal on the high plane which it has achieved in so short a period of time and I am happy that his temporary absence from the City has made it possible for me to steal a march upon him and, with the connivance of devoted admirers of his, arrange to insert in this, the first number of the Journal for 1953, an expression of our gratitude and appreciation for his work.

I am sure that he would never have allowed this all-too-inadequate tribute to be inserted had he had the opportunity to reject it. But he did not have that opportunity and I hope that all the members of the Faculty will rejoice with me that he did not. Otherwise we could not have joined together, as we do now, in saying—"Well done, George, and may your pen and blue pencil grow ever stronger as the years go on!"

Alan M. Chesney
Retiring President

CHARLES P. McCORMICK

President, McCormick and Company

* * * * *

An Expression of Gratitude

As President of the Baltimore City Medical Society, and on behalf of its Officers, the Executive Committee, and the entire Membership, I wish, through the medium of this Journal, to thank Mr. Charles P. McCormick, President of McCormick and Company, and his Senior Board for the wonderful gifts he has given to this Society; namely, Golde Model 1048 All Purpose Projector, Kodaslide Projector—Master Model with 5″ F 3.5 lens for 2 x 2 slides, Adapter for 2¼ x 3¼ slides, B & L Baloptican Table, Dalite Model, C 8 x 8 Wall Screen and 7½ F 4. lens. Slides can now be shown from the rear of Osler Hall and over the heads of the audience, the 35 mm. projector is for colored films; and to make the effect of these complete, the ultra modern screen, centrally placed on the wall, will prove a great help to late comers at the meetings.

I wish I could express more adequately my appreciation to Mr. McCormick for this marvelous donation. Knowing his great interest in human relations, I feel sure he will realize the tremendous educational value of this gift in attracting the tired "Doc" to attendance at more meetings.

With these new lanterns and screen, and other improvements made by the Faculty and the Baltimore City Medical Society such as; a new ventilating system, recording apparatus and loud speakers, together with more stimulating programs, there should be no limit to the educational progress of the Society in helping to make all of us better doctors. if we will only take advantage of our opportunities.

Again our thanks to McCormick and Company.

Wetherbee Fort, M.D.
PRESIDENT

* * * * *

Thank You, Mr. McCormick!

As Secretary of the Medical and Chirurgical Faculty and Editor of the Maryland State Medical Journal, I cannot let this opportunity pass without extending to Mr. Charles P. McCormick the appreciation of the members of the Medical and Chirurgical Faculty which comprise the doctors of the State of Maryland.

George H. Yeager, M.D.
SECRETARY

Scientific Papers

THE RECENT ADVANCES IN SURGERY OF THE AUTONOMIC NERVOUS SYSTEM*

OSLER A. ABBOTT, M.D.†

Much, in our knowledge, of the autonomic nervous system of the human is still speculative. Great may be the enthusiasm, great the confusion, and oft-times much the disrepute which surgical adventures into this field may produce. Why is there such a confusion in regard to this group of structures felt to be responsible for the stability of our internal environment, the so-called milieu interne of Claude Bernard? Certain it is that the autonomic nervous system of the human is part of a more intricate structure than the autonomic nervous system of the experimental animal. Parallel findings in regard to the function of the autonomic nervous system do not necessarily occur in different species of animals. Thus, in the dog, we find that stimulation of the vagus nerve produces both vasoconstrictor and vasodilator impulses going to the pulmonary vessels with a predominance of a dilatation effect.[1] On the other hand, stimulation of the vagus nerve in the rabbit produces only constriction of the pulmonary vessels. In similar fashion an experiment upon the dog is not necessarily reproducible upon the human autonomic nervous system. Dragstedt[2] has pointed out that transection of the vagus nerves in the dog will rather uniformly produce major constriction at the esophago-gastric juncture and mega-esophagus. Despite a large number of transthoracic vagus nerve resections in the human, to my knowledge, only one patient has had such a mega-esophagus-cardiospasm syndrome produced.

We feel justified, therefore, in a primary conclusion that the human autonomic nervous system not only may vary in its anatomical structure from that in the lower species but does not necessarily function in an identical manner.

We must further appreciate that the autonomic nervous system is not truly autonomic, or automatic, but is in varying degrees subject to some regulation by the higher levels of consciousness in different individuals. Our second premise, therefore, to explain the confusion in regard to the function of this nervous system, is that there must be, of necessity, some variation of function in this system in different human beings, varying with the degree of delicacy of development of the higher cortical centers and the degree of their influence upon thalamic centers. We will have more to say in regard to the conscious intelligence of the autonomic nervous system as this discussion progresses.

A third and major factor which we feel is of major importance in consideration of the application of our knowledge of the physiology of the autonomic nervous system to various pathological states in the human, will be the appreciation of the principle of cumulative or synergistic etiological agents in the production of a symptom complex. This third factor may be a source of some confusion, so let us discuss it in further detail. Since the time of Hippocrates, men of medicine have preferred to deal with a philosophy of the singular. Thus, when disease occurred it was considered that *one* of the "four humors" was out of balance. As the science of medicine progressed and the era of bacteriology presented, we became convinced of the efficacy of Koch's postulates. We assumed the habit of thinking that, because so many diseases were due to a single, separate, individual etiological bacterial agent, therefore not only a disease but a disease complex should be resultant to a single or individual cause.

---

* J. M. T. Finney Fund Lectureship presented at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, on Wednesday Morning, April 30, 1952, in Osler Hall.

† Assistant Professor of Clinical Surgery (Thoracic); Chief, Division of Thoracic Surgery, Emory University School of Medicine, Emory University, Georgia.

It is the author's definite conviction that as we grow in clinical acumen, we begin to realize that the more complex a disease, the more probable a synergism of multiple agents as a cause of its production. Certainly we are on the threshold of a conviction that many human carcinomas may be the result of the coordinative action of certain irritants, whether chemical or virus in nature, acting in an organ system, properly prepared by hereditary factors. The mystery of rheumatic fever becomes less incomprehensible as we understand the coordination of the streptococcus, allergy, heredity and specific connective tissue response. The interplay of emotional tension, heredity, and cholesterol physiology all have to be considered in so-called essential hypertension. The synergism of chronic irritation, a responsive autonomic nervous system and local areas of parenchymal lung damage, must be understood to realize the pathogenesis of pulmonary emphysema.

We feel that we must stress this complexity of synergism of agents in a responsive organ system if we are to properly apply any surgery of the autonomic nervous system. Experience has shown us that autonomic nervous system surgery alone, in the treatment of bronchial asthma, is almost constantly insufficient treatment. Removal of specific sources of irritation, whether intrinsic or extrinsic allergens or local areas of pulmonary disease, plus proper surgery of the autonomic nervous system, may be and is of major benefit in certain cases of bronchial asthma.

It is of major importance then for us to appreciate three significant factors in regard to any surgical attack upon the human autonomic nervous system in relation to disease complexes. First, the function of the parasympathetic and sympathetic nervous systems is not necessarily the same in the human and in the experimental animal. Second, the autonomic nervous system in the human is subject to a more highly developed cerebral cortical domination than occurs in the lower species. Third, surgery of the autonomic nervous system is most commonly applied to more complicated diseased states or syndromes in which disturbance of the autonomic nervous system is usually only one of several important synergistic factors producing the disease entity.

With this background of a realization of some of the confusing aspects of the problem, let us consider systematically: anatomy, function, and some of the recent advances in surgery of the autonomic nervous system. Intelligent surgery demands a major consciousness of the anatomic, physiological, and pathological aspects of the organ system involved.

The autonomic nervous system consists, essentially, of two main divisions; namely, the sympathetic or thoraco-lumbar outflow and the parasympathetic or cranio-sacral outflow (Fig. 1). The sympathetic division consists of cells arising in the lateral horns of the spinal cord from the 8th cervical to the 2nd or 3rd lumbar segments. The fibers arising from these axons are medullated and reach out to join outlying ganglia; and, as such, these fibers are called pre-ganglionic. The post-ganglionic fibers are non-medullated and consist of those which arise from cells of the ganglia. These pre- and post-ganglionic fibers are under the control of a higher center in the posterior region of the hypothalamus, and in varying degrees are subject to the domination of the cerebral cortex.

Although most textbooks consider that the sympathetic nerves are all motor or secretory in function, evidence is presenting that there must be afferent connections, that is, a sensory component to the sympathetic system as well as there is to the parasympathetic. Thus, the pain in the lower extremity which may be present in the individual with paraplegia may be interrupted by lumbar paravertebral block. Most of us, as physicians, are conscious of the sensory disturbance of an unpleasant nature which we note as a needle traverses the adventitia of one of our arteries, or veins.

cervical nerves, the middle cardiac nerve and the thyroid gland. Finally, the inferior cervical ganglion involves branches to the 7th and 8th cervical nerves, the inferior cardiac nerve, and aids in the formation of plexuses about the subclavian artery and such branches as the vertebral and axillary vessels.

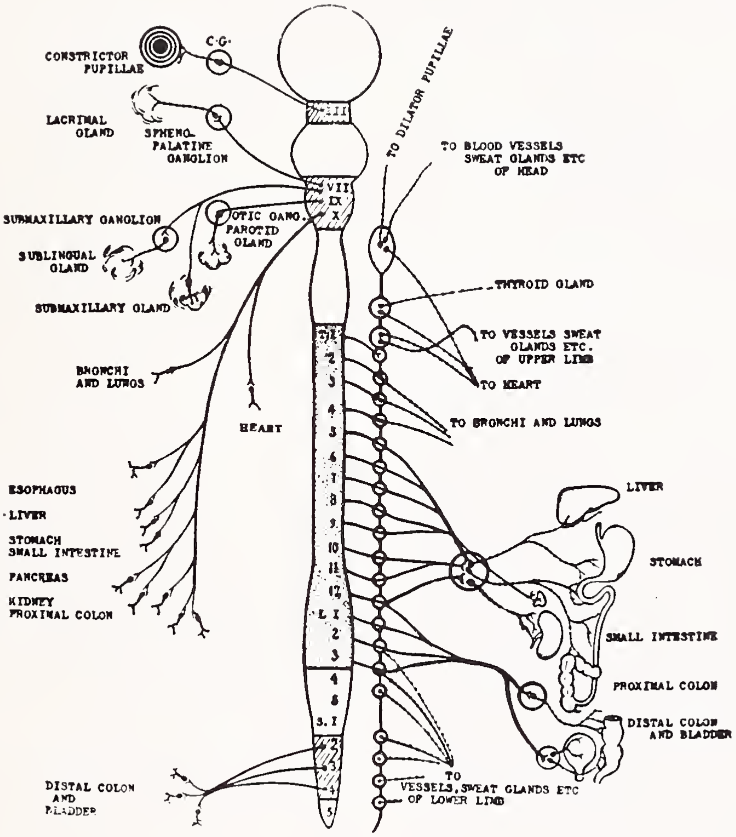

C·G·
CONSTRICTOR PUPILLAE
LACRIMAL GLAND
SPHENO-PALATINE GANGLION
SUBMAXILLARY GANGLION
OTIC GANG.
PAROTID GLAND
SUBLINGUAL GLAND
SUBMAXILLARY GLAND
BRONCHI AND LUNGS
HEART
ESOPHAGUS
LIVER
STOMACH
SMALL INTESTINE
PANCREAS
KIDNEY
PROXIMAL COLON
DISTAL COLON AND BLADDER
III
VII
IX
X
T.1
2
3
4
5
6
7
8
9
10
11
12
L 1
2
3
4
5
S. 1
2
3
4
5
TO DILATOR PUPILLAE
TO BLOOD VESSELS SWEAT GLANDS ETC OF HEAD
THYROID GLAND
TO VESSELS SWEAT GLANDS ETC. OF UPPER LIMB
TO HEART
TO BRONCHI AND LUNGS
LIVER
STOMACH
SMALL INTESTINE
PROXIMAL COLON
DISTAL COLON AND BLADDER
TO VESSELS, SWEAT GLANDS ETC OF LOWER LIMB

Fig. 1. Basic plan of autonomic nervous system. Note cranial and sacral origins of parasympathetic system, while sympathetic system originates from T_1 down to L_3. (Courtesy of Best & Taylor—"Physiological Basis of Medical Practice.")

Usually there are twenty-two sympathetic ganglia connected by intervening fiber tracts going to form the sympathetic chain which extends from the base of the skull to the sacral region. In the upper, or cervical part of the chain, we find three major ganglia known as the superior, middle, and inferior cervical ganglia. The superior cervical ganglion supplies the head, in particular the eye, ear, palate, upper cervical nerves, carotid sinus and carotid body, and a superior cardiac nerve. The middle cervical ganglion is concerned with the 5th and 6th

The thoracic region of the sympathetic chain consists of from ten to twelve ganglia, and usually the first thoracic and inferior cervical ganglia are fused to form what we call the stellate ganglion. The lumbo-sacral portion of the chain consists of four lumbar and four or five sacral ganglia. As the sympathetic fibers course towards the abdominal viscera, three further distributing points occur. These are described as the prevertebral ganglia and consists of: (a) the celiac, solar or semilunar ganglion, lying in relation to the origin of the celiac artery; (b) the superior mesenteric ganglion distal to the superior mesenteric artery, and (c) the inferior mesenteric ganglion. We must stress that the postganglionic fibers, or gray rami communicantes, join the spinal nerves close to the point at which the preganglionic fibers or white rami arise. Only those spinal nerves in the immediate vicinity of the ganglia possess white rami, but every spinal nerve receives a gray ramus. Thus, in the upper cervical, lower lumbar and sacral somatic nerves, impulses must travel a considerable distance up or down the sympathetic trunk before reaching an outlet through a gray ramus. Thus, excision of a ganglion may affect sympathetic pathways at a considerable distance. For instance, stellate ganglionectomy transects the sympathetic route to the head, neck, upper limb, and in part to the heart and lung. Some intermediate ganglia occur outside the sympathetic chain proper and a gray ramus, known as Kuntze's nerve, frequently occurs passing from the 2nd thoracic ganglia via the 1st thoracic nerve to the brachial plexus. This explains instances of incomplete removal of sympathetic supply to the arm following stellate ganglionectomy. As the sympathetic nerves leave the ganglia they may join with branches from the parasympathetic system; namely, the vagus to form plexuses. Thus, in the thorax are formed the cardiac, pulmonary, and esophageal plexuses.

Elongated white rami or preganglionic fibers, arise in the lower thoracic region. Thus, from the 4th or 5th thoracic segments to as low as the 9th or 10th may arise the preganglionic fibers which go to form the greater splanchnic nerve, and these end in the upper part of the celiac ganglion from which postganglionic fibers arise, going into the celiac plexus. Similar white rami arising from the 10th, 11th, and 12th thoracic and the first lumbar segments, pass without interruption through the vertebral ganglia to the prevertebral, or celiac ganglion, and form what are known as the lesser and least splanchnic nerves. Second and third lumbar segments give rise to preganglionic fibers which traverse the lumbar portion of the sympathetic chain, and enter the inferior mesenteric ganglion. These are known as the lumbar splanchnic nerves. The postganglionic fibers arising from these prevertebral ganglia; namely, the celiac, superior and inferior mesenteric ganglia, then blend with parasympathetic fibers to produce plexuses known as the celiac, superior mesenteric, intermesenteric, superior hypergastric and inferior hypergastric plexuses.

In summary, then, we note a distinct difference between the sympathetic nervous system to the viscera above the diaphragm, whereat all fibers leaving the vertebral ganglia are nonmedullated or postganglionic, while fiber tracts below the diaphragm may leave the vertebral ganglia as either pre- or postganglionic fibers, depending upon the presence or absence of interruption of their course within such ganglia. The splanchnic nerves therefore consist of white rami and consist purely of sympathetic nerve fibers. The various plexuses on the other hand, consist of postganglionic fibers which are blended with fibers of the parasympathetic system. A different physiological situation is produced by transection of a preganglionic, than by transection of a postganglionic, fiber.

The parasympathetic, or cranio-sacral division of the autonomic nervous system originates from cells in the mid-brain, the medulla, and the sacral region of the spinal cord. The axons, or preganglionic fibers of this system travel to ganglion cells closely adjacent to or within the organ which is to be innervated. Preganglionic fibers arising from the mid-brain travel to the nucleus of the oculomotor nerve and then pass on as postganglionic fibers, to terminate in the sphincter of the pupil and the ciliary muscle. The preganglionic fibers arising from the medulla leave the brain within the sheath of the facial, glossopharyngeal and vagus nerves. A great majority of these fibers proceed downward as the vagus nerve and are distributed to the thoracic and abdominal viscera.

Again, let us remember that the vagal fibers are long, preganglionic fibers and as such reach ganglion cells in the wall of the heart, intrinsic plexus of the bronchi, and the myenteric plexus of Auerback and the submucous plexus of Meissner in the esophagus, stomach and intestines. The sacral outflow of the parasympathetic system consists of anterior horn cells of the 2nd, 3rd and 4th, and sometimes the 1st sacral segments of the cord. After these fibers travel with the spinal nerves they separate from them and proceed, peripherally, as the pelvic nerve and enter into the formation of the pelvic plexus.

THE FUNCTIONAL ASPECT OF THE AUTONOMIC NERVE SYSTEM

In the main, the function of the autonomic nerve system is to control and to perceive physiological activities below the upper levels of consciousness. The system is not truly autonomic but is under the direct control of centers within the central nervous system below the level of the cerebral cortex but can, in varying degrees, respond to cerebral cortical activity. This system, then, is in the main concerned with balances of the body with its internal environment while the voluntary system modulates the balance of the body with the external environment. Cannon[3] speaks of the homeostasis produced by the autonomic nervous system in a healthy body. He considers that the essential function of the parasympathetic and sympathetic systems is to regulate the internal adjustments upon which a constancy of body health depends. The two parts of the autonomic nervous system then act as balancing agents. The vagus nerve inhibits cardiac action, the sympathetic system augments it. Salivary glands are stimulated to secretion by the parasympathetic system, their secretion decreased by the sympathetic system. Bronchi contract upon stimulation of the vagus and relax under the influence of adrenalin. In the main, the sympathetic system is involved with the production of human energy, while the parasympathetic system is more interested in conservation and restoration. The shorter preganglionic fibers of the sympathetic system are concerned, then, with the shorter strenuous activity of brief aggression. The longer preganglionic fibers of the parasympathetic system are more concerned with the longer periods of relaxation and restoration. Removal of the effects of one of these systems usually results in the enhancement of the activity of the other system.

THE INTELLECTUAL CONSCIOUSNESS OF THE AUTONOMIC NERVOUS SYSTEM

For some strange reason there has been a prolonged contention in medicine that the autonomic nervous system does not transmit sensations to the higher levels of consciousness. This premise is now unacceptable. There is, however, a great variance in the degree with which a person is conscious of sensations transmitted by the autonomic nervous system. The sensation is often bizarre, and the description of such sensation varies greatly with the intellectual caliber and sensitivity of the patients. We know that the severe constrictive sensations of pain, association with acute occlusion of the coronary artery blood flow, have in several instances been completely interrupted by removal of certain of the upper dorsal sympathetic ganglia. Drs. Curtiss and Klassen have very beautifully demonstrated the sensory component of the vagus nerve in regard to the tracheobronchial tree. They have proven the presence of pain sensation in the vagal nerve filaments in the bronchial plexus. They were able to outline for us the areas in which tracheal painful stimulation is subjectively perceived, in contra-distinction to the areas in which such bronchial painful sensation is noted. Those of us in thoracic surgery who have been indulging in denervation procedures relative to the lung and thoracic viscera, have been tremendously impressed with the sensory component, the sensations carried by the afferent fibers, of both the sympathetic and the parasympathetic system.

Gastroenterologists tell us that certain highly integrated patients following vagotomy for gastro-intestinal tract disease, have complained about a lack of certain sensations which they noted periodically during their waking hours prior to such an operation. Apparently many of these sensations are constantly bombarding the hypothalamic area in the normal state and a distinct absence of them is noted by some patients following vagotomy. Peptic ulcers have been noted to perforate painlessly following transection of the parasympathetic nerves.

Seven years ago we became impressed by the occasional bizarre symptom described by patients with thoracic disease. Symptoms which, in themselves, practically outlined the size and character of the lesion harbored by the patient. We soon developed a high regard for the varying intellectual consciousness of the autonomic nervous systems in different patients. We have made a plan for testing this premise by obtaining the maximum amount of information, no matter how apparently bizarre, from any patient prior to intrathoracic surgery. Following excision of lesions, or transection of autonomic nerves, the patients are then re-examined and questioned in regard to sensations which have now disappeared. They are also interrogated at length in regard to any sensations prior to operation about which we did not have the knowledge or intelligence to inquire. As this knowledge increased we began to ask direct and important questions of patients at the time of their initial visit. By this means we now realize the volume of lesions which have been thought to be non-symptom producing, which actually have their own symptom complex.

Let me emphasize this point by describing in detail a single patient sent to us with the description, by her physician, that "a totally asymptomatic lesion had been discovered upon screening x-ray examination." Following our standard procedure of insisting upon obtaining the history, both from the patient and her most intimate relative, the following story was evolved.

Mrs. E. J. W., a thirty year old white female, was seen with the clinical complaint of "a large, totally asymptomatic mediastinal tumor." For approximately 12 to 14 months the husband had been conscious of the wife's breathing when she was asleep and felt she breathed more rapidly, more loudly, and with a different rhythm than he did. He had noted that she became distinctly more dyspnoeic than he, on approximately equal effort. For six months the patient had noted a vague sensation of uneasiness in her chest which she found "hard to define." In the main, this was a sensation of localized tiredness in the region of the left interscapular region. Effort increased this local vague fatigue. Tachycardia, without apparent cause, had occurred for six months, sufficient for her to frequently ask her husband to feel and count her heartbeat. For four months lying on her left side has made her have an internal sensation of feeling that she might be near death. Such a sensation was relieved by lying upon the right side. For one year she had experienced peculiar feelings in both wrists and hands, particularly with fatigue. This was described as a numbness and a sensitivity to temperature change.

It is only too easy to see how a patient with this symptom complex presenting herself to physicians without a knowledge of the intellectual consciousness of the sympathetic system, might accuse the patient in his own ignorance of having a psychic or psychosomatic disorder. We can assure you that the objective findings noted by the husband occurred eleven months prior to any knowledge of the presence of the tumor which was revealed at that time by the first x-ray. The patient had complained to the husband, spontaneously, of bizarre chest sensations, bizarre sensations of the upper extremities, tachycardia, and vague localized fatigue discomfort many months prior to any knowledge of organic disease.

At the time of surgery the tumor proved to be a neurofibroma arising in the left posterior mediastinum, causing distinct compression of the adventitia of the aortic arch with resultant sensory disturbance. There was also major compression of the dorsal sympathetic chain. This is far from an isolated instance. Only too commonly we shudder when the carcinoma of the lung patient tells us of deep, vague pain in the ear of the side involved. Similarly, he may describe hyper-salivation or bizarre behaviour of the gastro-intestinal tract. Such patients, on exploration, will reveal invasive destruction of the vagus nerve on the side involved. Much could be written and much awaits to be written in regard to the intellectual component of the autonomic nervous system.

THERAPEUTIC TRIALS OF AUTONOMIC NERVE SURGERY

The author has chosen not to give a detailed review of the literature in regard to recent advances in autonomic nerve surgery. He has preferred to allow a reflection of such advances in the literature as might be shown by experiences of the application of such knowledge by various members of the surgical staff of the Emory University School of Medicine. Autonomic nerve surgery at this Clinic is carried out by four major groups. The Neurosurgical Group, consisting of Drs. Edgar F. Fincher and Homer Swanson, has been particularly interested in the neurosurgical syndromes which can be affected by autonomic nerve surgery. As such, they have been particularly interested in the relief of pain such as is produced in causalgia, the headache problem, cerebral vascular spastic disease, hypertension, and some peripheral vascular disease. The Vascular Surgical Group, consisting of Drs. D. C. Elkin and Frederick C. Cooper, has been particularly interested in regard to peripheral vascular disease. The Thoracic Surgical Section, consisting of the author and Dr. William A. Hopkins, has mainly been interested in the application of autonomic nerve surgery to diseases of the thoracic viscera. The fourth group at Lawson V. A. Hospital has been under the consulting direction of the other sections.

Chart No. I presents an over-all summary of the diseases or syndromes which have been attacked and outlines the relative efficacy of the procedures. It designates whether the operative attack is upon the sympathetic system, the parasympathetic system, both of the autonomic nerve systems or the use of autonomic nerve surgery as an adjunct to other surgical procedures.

We would like to stress that this outline summarizes our concept of autonomic nerve surgery carried out during or after the second World War. There are two definite periods in regard to autonomic nerve surgery; the period prior to the second World War constitutes a rather pessimistic period in regard to this type of surgery due, in the main, to a poor understanding of the disease complexes and, in general, a marked tendency to incomplete neurectomy. The second, or post-war period, consists of a period of optimistic advance due to better physiological understanding, improvements in pharmacology, diagnostic techniques and more complete surgical attack.

In the evaluation of a surgical procedure, the fundamental question in such an impression is whether we choose to criticize the procedure in regard to a single or group of objective tests following surgery, or whether we choose to evaluate the degree of restoration of economic and social well-being. In other words, the evaluation differs whether the physician is fundamentally an academician, or an humanitarian. Again, it is the author's distinct impression that this segregation of the academic and social aspects of medicine will achieve better blending as we attack the multiple factors involved in the synergistic etiology of disease complexes. The predominance with which autonomic nerve disturbance is responsible for a disease syndrome should, and, I do believe, does parallel the efficacy of this branch of surgery.

Let us now briefly discuss the factors presented in Chart No. I. At a recent meeting of the Cushing Society, Dr. Wm. A. Nosik described two patients achieving very dramatic results from section of the superficial petrosal nerve for the control of the pain and increased lacrimation involved in bullous or vernicular conjunctivitis. This is a very recent observation and will deserve further inquiry. The Emory University Neurosurgical Group has had opportunity to treat 10 patients with cerebral erythromelalgia, which has also been described as histamine, Horton's headache, and Gardner's disease. Five of these 10 patients who had superficial petrosal neurectomy achieved dramatic relief of symptoms. In the other five the result was only partially satisfactory.

CHART I—A

Therapeutic Trials of Autonomic Nerve Surgery (Neurological)

DISEASE OR SYNDROME	SYMPATHECTOMY	PARASYMPATHECTOMY	BOTH SYSTEMS	ADJUNCTIVE SURG.	EFFICACY
Bullous ophthalmia	Sup. petrosal N.	—	—	—	Promising
Migraine headache	Stellectomy	—	—	—	Poor
Idiopathic epilepsy	Stellectomy	—	—	—	Poor
Focal cerebral vasospasm	Stellectomy	—	—	—	Curative
Occlus. cerebral vasc.	Stellectomy	—	—	—	Poor
Cerebral air embolism	Stellate block	—	—	—	Promising
Cerebral erythromelalgia	Stellectomy	—	—	—	Good
Atypical facial neuralgia	Yes	—	—	—	Poor
Cerebral aneurysm	Stellectomy	—	—	Exclus. aneurysm	Good
Major causalgias	Yes	—	—	—	Curative
Paraplegia c̄ causalgias	Yes	—	—	—	Good
Minor causalgias	Yes	—	—	—	Poor
Phantom limb	Yes	—	—	—	Poor
Post-poliomyelitic limb	Yes	—	—	—	Poor
Shoulder-hand syndrome	Yes	—	—	—	Unnecessary
Essential hypertension	Splanchnicectomy D5-L2	—	—	—	Good

CHART I—B

Therapeutic Trials of Autonomic Nerve Surgery (Peripheral Vascular)

DISEASE OR SYNDROME	SYMPATHECTOMY	PARASYMPATHECTOMY	BOTH SYSTEMS	ADJUNCTIVE SURG.	EFFICACY
Lymphedema, idiopathic	Yes	—	—	—	Poor
Lymphedema, post-mastectomy	Yes	—	—	Scalenotomy	Good
Thrombophlebite states	Yes	—	—	—	Harmful
Raynaud's disease	Stellectomy, D1, 2, 3	—	—	—	Good
Buerger's disease	L1 & L2	—	—	—	Good
Traumatic vasc. occlusions	Yes	—	—	—	Good
Embolic or thrombotic occlus.	Yes	—	—	—	Good
Arteriosclerosis	Yes	—	—	—	Good
Post-trauma vasospasm	Yes	—	—	—	Curative
Frostbite, trench foot	Yes	—	—	—	Curative
Hyperhidrosis	Yes	—	—	—	Good
Orthostatic ulcers	L1 & L2	—	—	—	Variable
Peripheral aneurysms	Yes	—	—	Aneurysmectomy	Good*
Peripheral A-V fistulas	Yes	—	—	Aneurysmectomy	Good*

* Probably necessary only in older patient group.

A great deal of work has been done elsewhere in regard to stellate ganglionectomy in the control of migraine headache. Despite the enthusiastic reports of some, the consensus of opinion in this country is that the procedure is not of value. Similar conclusions must be held in regard to stellate ganglionectomy as an aid in the palliation of idiopathic epilepsy.

Chart I—C

Therapeutic Trials of Autonomic Nerve Surgery (Abdominal Visceral)

DISEASE OR SYNDROME	SYMPATHECTOMY	PARASYMPATHECTOMY	BOTH SYSTEMS	ADJUNC. SURG.	EFFICACY
Chronic pancreatitis	Splanchnicectomy, D9-12	—	Tried	—	Good
Carcinoma pancreas	Splanchnicectomy, D9-12	—	—	—	Palliative
Abdom. causalgia	Splanchnicectomy, D9-12	—	—	—	Palliative
Tabetic crises	Splanchnicectomy, D9-12	—	—	—	Curative
Megacolon	Tried	Tried	Tried	—	Poor
Cystic fibrosis pancreas	Splanchnicectomy, D7-L2	—	Deserves trial	—	Poor
Intractable pain (neoplastic)	—	—	Presacral N	—	Poor
Dysmenorrhea	—	—	Presacral N	—	Poor

Chart I—D

Therapeutic Trials of Autonomic Nerve Surgery (Thoracic Visceral)

DISEASE OR SYNDROME	SYMPATHECTOMY	PARASYMPATHECTOMY	BOTH SYSTEMS	ADJUN. SURG.	EFFICACY
Intractable angina pectoris	Stellectomy, D1-5	—	—	Pericardineurectomy	Good
Cardiac arrythmias	Stellectomy, D1-5	—	—	—	Unknown
Cor pulmonale	—	—	Complete plexectomy	—	Palliative
Tetralogy of Fallot (absent pulm. art.)	Stellectomy, D1-5	—	—	Arietal pleurectomy	Good
Aortic aneurysms	Stellectomy, D1-L2	—	—	Aneurysmorrhaphy	Good
Bronchial asthma	(Adrenalin resistance)	—	Complete	Excise trigger area	Good
Pulm. emphysema	—	—	Complete	Excise trigger area	Good
Severe bronchorrhoea	Stellectomy, D1-5	—	—	—	Palliative
Recurrent pneumothorax	—	—	Complete	Excise trigger area	Curative
Incurable neoplasms	Stellectomy, D1-5	High rt. vagotomy	—	—	Palliative
Cardiospasm, megaesophagus	Tried	Tried	Tried	Tried	Harmful

A major argument still prevails in regard to the degree of control of the cerebral vessels by the sympathetic nervous system. Our neurosurgical group feels firmly convinced that stellate block, or stellate ganglionectomy, are of no demonstrable value in the treatment of patients suffering occlusive cerebral vascular disease. We reserve some opinion in this regard relative to the use of rather high doses of intravenous novocain when faced with small cerebral air emboli. Drs. Fincher and Swanson have had experience with a small group of six patients presenting multiple seizures of cerebral cortical origin. In the main, these patients have been in the upper age groups and the syndrome has consisted of rather sudden loss of use of an extremity, followed by clonic seizure of the involved extremity, and then immediate return of function of the involved area. Such transient attacks suggest, strongly, a local area of cerebral vascular spasm and predicate the absence of permanent, occlusive phenomena. These two physicians wish to stress that this is a very select group of patients and is not occlusive vascular disease. These are patients suffering "transient episodes of irritative, focal cerebral upheavals that suggest a vasospastic factor and in whom all studies, aside from angiography, were negative for permanent structural cerebral damage." In these six patients stellate ganglionectomy on the involved side was carried out. In all, a very beneficial result with release from further convulsive episodes was achieved. This is a group of patients about whom further major studies are indicated.

There has been one patient in whom a cerebral arterial aneurysm had been controlled by an exclusion procedure, but the patient persisted in having severe unilateral headache. Repeated stellate nerve blocks demonstrated relief of pain, and finally permanent relief of the hemicranial headache was achieved by stellate ganglionectomy. It is the opinion of the neurosurgical group, that stellectomy is an unsatisfactory procedure in the so-called atypical, facial neuralgias. It is, furthermore, their opinion that patients suffering the so-called shoulder-hand syndrome following coronary occlusion, should not be subjected to autonomic nerve surgery. In the main, these patients will recover both function and comfort if they are willing to tolerate four to six months of pain and proper physiotherapy.

Autonomic nerve surgery for the various so-called idiopathic lymphedemas, such as Milroy's disease, etc., is an ineffectual procedure. However, there has been a small group of patients who have had lymphedema of the arm following radical mastectomy. These patients, totalling only three in number, have had lymphedema and considerable arm and shoulder pain as the presenting symptoms. The weight of the arm itself has played a distinct role in producing a scalenus type of syndrome; therefore, these three patients were treated by means of a complete decompression of the brachial plexus by scalenotomy and a concomitant stellate ganglionectomy. In all three patients the swelling has disappeared and they have no residual pain. We wish to stress that this operative procedure is a combination of stellectomy and decompression of the brachial plexus.

A total of six patients with Pancoast's syndrome have been treated either by the author or by Dr. Swanson with attempts to alleviate pain. The procedures involved have included a decompression of the thoracic inlet with or without lobectomy, along with stellate ganglionectomy and upper dorsal sympathectomy. The pain related to the scalenus portion of the patient's difficulty, the pressure of the mass in the thoracic inlet, and the causalgia have been alleviated in the main, but the longevity of the patient has not allowed sufficient observation to determine whether this operation is really worthwhile. It is certain that if one can relieve the pain in Pancoast's syndrome or apical pulmonary carcinoma, that longevity is increased. Our experience with prefrontal lobotomy in this disease has been very limited but has indicated prolongation of life and maintenance of weight for a longer period than seen in the untreated group. It is difficult to become enthusiastic about palliative procedures in carcinoma and we would much prefer to stress the factors of early diagnosis with the possibility of curative resections.

Let us turn now to a discussion of the various causalgias and our experiences in treating them with autonomic nerve surgery. The Neurosurgical Group has treated somewhat over 100 patients with different causalgias. In 84 patients presenting major causalgias without any overlying pension claims, distinct and dramatic benefit was obtained in all. In the early stages of this work, sympathetic nerve block injections were carried out but were soon discontinued as the clinical syndrome became better clarified and one could clinically predict the results without preliminary sympathetic block. The results in the treatment of minor causalgias has been considerably different. There has been a uniform poor result or failure in sympathetic surgery in patients with minor causalgias with associated Workman's Compensation or pension claims. Thirty per cent of a group of private patients with minor causalgias and a sincere desire to get well have shown distinct benefit from this surgery. The minor causalgias emphasize then the factor of the selection of patients with consideration of their disease, personality, social and economic problems. It should be mentioned that 70 patients with major causalgias, discussed above, were operated upon by Dr. Swanson during his service in the Army Medical Corps.

The Vascular Surgical Group, consisting of Drs. D. C. Elkin and Fred F. Cooper, have had extensive experience with autonomic nerve surgery, particularly in reference to diseases of the extremities. 640 sympathectomies were carried out by this group during their service with the Vascular Disease Center of the Army Medical Corps at the Ashford General Hospital. These operations involved all extremities including both dorsal and lumbar sympathectomy. Since return from the service these men have carried out 150 further sympathectomies for diseases of the extremities. A brief summary of their experiences is as follows.

First, there is a group of patients with post-traumatic vasospastic states, including such diseases as post-traumatic dystrophy, Sudeck's atrophy, etc. Such patients are not considered for autonomic nerve surgery if their disease is characterized by only minimal or mild osteoporosis, for this group of patients can obtain clinical relief of symptoms by proper physiotherapy. In the more advanced patients with intractable pain, sympathectomy has been carried out and the result has been uniformly successful with no single incidence of failure.

A second group of patients are those who are suffering from pain following frostbite, or trench foot, namely, they are injuries due to cold. Their feelings in this regard is that if surgery is carried out in the early stages, the vasospastic phenomena and hyperhidrosis are relieved. It appears that the earlier the surgery the more rapid the disappearance of pain in the foot. In twelve specific instances in which the disease was more marked on one side, a unilateral sympathectomy was carried out. In all twelve of these patients the unilateral relief was so great that they insisted upon surgery being done upon the other side. Following surgical intervention, objective tests such as skin temperature and platysmographic studies return to normal, or above normal levels. Patients have a great relief of their vasospastic phenomena but it must be stressed that the deep pain in the ball of the foot, or heel, which may be described as either deep pain or tenderness, will only be improved but rarely, if ever, abolished. One should also mention that the surgery in these patients was carried out usually about two weeks after the injury, and none was carried out in the actual acute phase of the disease. The indications for surgery in this group consist, in the main, of visible evidence of persistent vasospastic phenomena. A very difficult group with this disease are those patients having the milder form without obvious visible evidence of vasospasm. This group constitutes a major problem in regard to pension claims by the Veterans Administration. Again, much emphasis is laid upon an analysis of the patient's personality and "pension" attitude. It is not felt, relative to this group, that there are any valuable objective tests to correlate, or to evaluate, the true degree of symptomatology. Valuable objective tests appear only to be present when visibly evident vasospasm occurs.

Thirdly, there is a group of patients with Raynaud's disease. There is some definite variance of opinion between the experiences of our Vascular Surgical Group and the Neurosurgical Group in the results of Autonomic surgery in this disease. The Vascular Surgical Group has been impressed with the multiple factors involved in Raynaud's disease. Thus, a considerable number of patients seen at the Ashford General Hospital had apparently had true demonstrable Raynaud's disease, while on active duty in the North Atlantic or Northern European Theatre of Operations. With release of the mental strain associated with active military service and the marked change in climatic conditions on return to this country, a large number of patients had a complete release from all Raynaud's disease symptomatology. In many, the disease could no longer be proven to be present by objective tests. The factors, then, of emotional strain and climatic conditions must be thoroughly evaluated before recommending autonomic surgery. A probable factor in the confusion in the literature relative to Raynaud's disease is, that there appears to be a distinct difference in the types of disease seen in different areas of the U.S.A. It is necessary to remember that the group under discussion here, is a group of patients from the South, who are exposed to much milder degrees of cold and temperature change than the group, for instance, which might be seen in the extreme Northern States. There is a distinct possibility that there may be a greater proportion of the emotional factor, and a lesser factor in regard to climatic conditions, in the group which we see at Emory University Hospital.

It is certainly worthy of mention that Raynaud's disease is not a disease restricted to the female but is seen definitely in both sexes. Furthermore, the disease is apparently not confined to the upper extremities. Our experience has shown that the immersion of hands in ice water is a poor test for this disease. A more preferable test is to immerse the patient in a cold shower for one minute, and this will bring out the stigmata of the disease if they are present. Such a method of testing has revealed that 80 per cent of the patients with Raynaud's disease will also show definite blanching of the feet. This is not noted by the patient because these areas are covered. They are less exposed to climatic factors and apparently they are less sensitive than the upper extremity. One sympathectomy has been carried out for lower extremity disease of Raynaud's type.

The experiences with sympathectomy for this disease by the Vascular Surgical Group has been confined to those patients with milder to moderate forms of the disease without evidence of trophic changes or scleroderma. These are the patients who may show benefit. In following up this group of patients, only 20 per cent have showed complete cure; 40 per cent have shown from marked to moderate remission of symptoms, while in the remaining 40 per cent only slight or no remission has occurred. There appears to be a very major problem to be settled in this regard. Despite preoperative objective tests and clinical evaluation, we do not seem to be able to discern before the operative procedure, which patients will benefit and which will not. Rare patients have been operated upon in whom scleroderma, trophic skin changes, or the so-called recurrent paronychia, which are thought to be areas of ischemic inflammatory necrosis, were present. There have been no valid cures in this group. It must be mentioned in considering the surgical approach to Raynaud's disease, that the emotional factor is deserving of major investigation. It is not uncommon to have a patient who is relieved of the visible evidence of Raynaud's disease, to be much disturbed by the increased perspiration over the back which may be very annoying to the vanity of certain women.

Finally, in the consideration of vasospastic states, there has been a very small group of three patients with idiopathic acrocyanosis of the hands. This is not a symptomatic patient group. The complaint, apparently, is purely cosmetic because of the dark blue color of the fingers and fingernails. Following surgery these patients uniformly transform this color to a bright red and, in some cases, the patient may find this to be an equally displeasing appearance of the upper extremity.

The Neurosurgical Group has carried out sympathectomies upon 75 patients with Raynaud's disease. All of these patients have had stellectomy and upper dorsal sympathectomy. One patient with a Raynaud's type syndrome in the lower extremity has been operated upon with apparent success. The feeling of the Neurosurgical Group is, that the results are satisfactory if no scleraderma is present and the patient cooperated in complete abstinence from tobacco.

There have been eleven patients operated upon for hyperhidrosis. Six had major complaints in regard to the upper extremities and were treated purely by excision of D_2 and D_3 of the sympathetic chain to control the symptoms in the axilla and hands. The results in this group have been satisfactory except for the complaint of increased perspiration being produced by this procedure in the lower non-sympathectomized body segments. Five patients were seen, suffering from severe hyperhidrosis of the lower extremities after trench foot. Indication for the procedure in these patients was that there was such severe hyperhidrosis that foot maceration, due to the fungus infection present, was a major factor. It was notable that all five of these patients appeared to be abnormally emotionally labile. Surgery appears to relieve the extremity but does not improve the personality. It is also notable in this patient group that there was no evidence of increased perspiration elsewhere after sympathectomy of the lower extremities.

Let us now turn to the problem of autonomic nerve surgery in patients with essential hypertension. The surgical work in this regard has been carried out, both by the Neurosurgical and the Vascular Surgical Group. These men have operated upon 118 patients in the past twelve years with essential hypertension. They would like to stress that no patients in Group I, and only patients in Group II with major symptoms, and patients in Group III have been operated upon. Their experience suggests that no single test or combination of tests gives one a guide to predict what the blood pressure response will be, following surgery. A study, therefore, of the correlation of the preoperative amytal test and cold pressure test has not predicted which of the patients will show a substantial decrease in systolic and diastolic blood pressure. This group has utilized both the Peet procedure, involving a dorsal sympathectomy from D_5 down through L_2, and the more extensive sympathectomies such as suggested by Smithwick. They conclude, that the simpler operation is equally effective to the more extensive one, and is less encumbered by the orthostatic hypotensive symptoms produced by the more extensive procedures. Certainly, if one evaluates the results of autonomic nerve surgery in essential hypertension purely by the response of the blood pressure, one would have to conclude that it is a very unsatisfactory operation. Again, we feel that this is evidence that the autonomic nervous system imbalance is only one of several synergistic factors producing the symptom complex. If, however, one criticizes the results of autonomic nerve surgery in essential hypertension, by evaluating the eradication of symptoms and the rehabilitation of the patients, one becomes most enthusiastic and optimistic about the procedure. In the 118 patients operated upon, all had major symptomatology. It is gratifying to note that there has been a uniform relief of symptoms in all patients. These patients have experienced relief from headache, improvement in vision, freedom from what they have described as previous "intractable nervous jitters," easy fatigability, and abdominal distress. Only 20 per cent of the group have had a return of the blood pressure to normal levels. All but three patients have gone back to varying periods of a normal living regimen. This cannot be expected if the patient has experienced heart failure, or definite renal damage, and these patients are usually excluded from operative consideration.

PERIPHERAL VASCULAR DISEASE SECTION

The experiences of this Clinic, in regard to occlusive peripheral vascular disease has been quite extensive. The combined experience of the cardiovascular and neurosurgical groups involves over 200 patients so treated. Our experience has shown us that in all patients with chronic vascular occlusion in whom the disease is stationary and non-progressive, that definite improvement may be expected by surgery of the sympathectomy nerve system. There is, however, a distinct variability in regard to the symptomatic improvement obtained, such as the pain of intermittent claudication. It is important to stress that these patients frequently do not show major improvement for three or four months following surgery, and such progressive improvement may continue for as long as from 12 to 18 months following the operation. In rare instances one may get immediate dramatic improvement.

Let us first consider the patients with arterial injuries in whom there is normal or increased vasomotor tone. Sympathectomy has been uniformly beneficial. The degree of benefit appears to depend markedly upon (1) the site of vessel injury, and (2) the functional resultant circulation following such injury. Thus, the patients with less impoverished circulation will do exceptionally well after sympathectomy. There is a distinct difference, then, in regard to an injury to the popliteal artery which will produce marked restriction of circulation compared to an injury to the superficial femoral artery wherein resultant circulation may be fairly good.

Follow-up study of this patient group suggests that the major visible improvement is noticeable in the skin and superficial tissues, a disappearance of pallor on elevation. The degree of disappearance of symptoms depends upon the degree of correction of their ischemic neuritic basis. Such improvement is noted, not only subjectively but also upon objective tests. The feeling of the Vascular Surgical Group is, that the more severe the ischemia the greater the need for immediate surgery. Thus, when confronted with irreparable arterial injury with major ischemia, we do not recommend initial treatment with nerve blocks of the sympathetic chain. The results of such blocks is usually only a periodic relief from vasoconstriction; such blocks may be ineffective and subsequent surgery is usually made more difficult.

The problem of Buerger's disease again stresses the synergism of multiple factors in the production of a disease complex. Furthermore, this is a disease characterized by remissions and exacerbations; therefore, only long-term follow-up studies may lead to worthwhile conclusions. Again, it may be of value to remember the fact that Buerger's disease is not a disease confined to the lower extremities. In 40 per cent of the patients seen by the Vascular Surgical Group, it has been noted to be present to some degree in the upper extremities. Buerger's disease of the brain has been reported. The Thoracic Surgical Group has had personal experience with two patients primarily presenting Buerger's disease of the lung, both of whom ultimately succumbed to acute mesenteric thrombosis.

It would appear certain that there is a marked variance in the efficacy of the surgery in this disease according to the timing of the sympathectomy in regards to the cycle of the disease. Thus, in patients in whom the disease appears static or suggestively "has run its course," in whom there is no active thrombosing phenomena, sympathectomy will produce uniform and marked improvement. In a second group of patients with mildly active disease characterized usually by vasospasm and only mild thrombotic activity, this type of surgery uniformly produces marked improvement. In such patients one will frequently notice previously chronic intractable small areas of ulceration, healing rapidly within two or three weeks following surgical intervention. On the other hand, in a third group of patients having severe fulminating disease who fortunately are but a small percentage of the total patient group, the disease is usually too progressive to allow adequate postoperative evaluation. The results of surgery in such patients have been most unsatisfactory.

Again, the multiplicity of factors in Buerger's disease is presented. Thus, a patient with ulceration and purulent material under tension who persists in smoking, will obtain no relief from sympathectomy. If one can achieve, in such a patient, release of the pus under tension, release from the stimulation of tobacco and release from sympathetic innervation, dramatic relief will be obtained. The long-term follow-up of patients with Buerger's disease has shown that persistent and continued improvement has only been present in those patients who have never again indulged in the tobacco habit.

Previously there was little enthusiasm relative to the value of autonomic nerve surgery in the treatment of patients with occlusive peripheral vascular disease due to arteriosclerosis. We now know that such individuals with normal vasomotor tone can be helped. As in other chronic occlusive vascular disease, the results of treatment show a considerable variance. Certainly the better results are obtained in patients presenting solitary areas of segmental occlusion. These patients should be treated prior to trophic changes. It is also interesting to note that those patients in whom the obstruction is nearer to the aortic outflow of blood, obtained the greater symptomatic relief. Thus, a patient with thrombosis of the lower aorta or iliac arteries obtained a greater degree of symptomatic relief than patients with destruction of the popliteal artery or lower tibial vessels. The resultant circulation is probably better in the former group because of a large number of available collateral vessels. The presence of diabetes mellitus was not felt to play any major part in the results obtained. In the main, if the diabetes is found to be under poor control and the patient develops a local area of gangrene due to trauma with infection, the underlying circulation will usually be sufficiently extensive to expect a satisfactory result. In general, then, in the arteriosclerotic group the patients in whom local gangrene is precipitated by trauma or infection rather than by extremely extensive diffuse disease, sympathectomy may be of value. Often, it will eventuate in the patient receiving relief by local amputation of a digit; whereas, without sympathectomy, a major amputation might be required. Our Group does not feel that sympathectomy will allow an amputation below the knee in major gangrene.

One is always impressed with the severe painful vasospasm associated with the acute occlusion of an artery, either by an embolus or by the formation of a thrombus in the area of an atheromatous plaque. If successful restoration of continuity of the vessel can be accomplished by embolectomy, sympathectomy is not considered necessary. However, if adequate restoration of blood flow cannot be obtained, then sympathectomy may produce a dramatic and successful result. In the treatment of embolic phenomena one must stress that efforts must be made to prevent extension of the thrombus by use of anticoagulants such as heparin.

We are not pleased with the results of sympathectomy in patients with thrombophlebitis. In all, 17 patients were treated, in whom there was evidence of venous insufficiency without skin lesions, without hyperhidrosis, but with increased vasomotor tone. These patients are frequently made tremendously worse by sympathectomy and its use is to be condemned. We would prefer to control the chronic eczema in such patients by other means. Our Group has not personally sympathectomized patients with lymphedema of the lower extremity, such as that resultant from Milroy's disease. A considerable number of such patients operated upon elsewhere have presented themselves for evaluation, and the conclusion is that these patients have not been benefited by the procedure.

Before departing from the topic of peripheral vascular disease and autonomic surgery we should mention that problem of the need of sympathectomy in patients undergoing surgery for arteriovenous fistula. More than 450 patients with arteriovenous fistula were operated upon under the direction of Dr. D. C. Elkin at the Ashford General Hospital. All these patients were operated upon without the adjunctive use of sympathetic surgery. Dr. Elkin would like to stress that these patients were patients in the younger age group of 40 and below. He does feel that sympathectomy is of value in the surgery of arteriovenous fistula in patients in the older age group. A similar consensus of opinion is held in regard to the surgery of peripheral aneurysms, 150 of which were operated upon in the younger age group.

Autonomic Surgery for Diseases of the Abdominal Viscera

The autonomic nerve surgical aspect of abdominal disease is apparently very much in its infancy. Trials of autonomic nerve surgery in regard to certain lesions of the gastro-intestinal tract, have frequently been disappointing; probably, in the main due to the fact that this approach was utilized prior to a proper understanding of the pathology and pathogenesis of the disease complex under consideration. Certainly autonomic nerve surgery, either sympathectomy or parasympathectomy, for cardiospasm was most disappointing. We are now beginning to appreciate the absence of Auerbach's plexus in the lower esophagus, in these individuals, and some similarity of this disease to the paucity of plexus fibers in the lower sigmoid and upper rectum of the patients with mega-colon. It is not surprising, therefore, in reviewing our experiences with such an approach to these two diseases, that vagotomy in combination with the Finney type of esophago-cardioplasty has not led to good long-term postoperative results. In similar fashion the rare patient with mega-colon, treated either by presacral neurectomy or by a combination of lumbo-dorsal sympathectomy and presacral neurectomy has not been helped.

The members of our Clinic do not feel justified in making any definite conclusions in regard to the role of vagotomy treatment of peptic ulcer. Our experiences do suggest that vagotomy yields a marked variance of clinical results. We are much impressed with the personality factor in these individuals. The markedly emotionally individual appears to be happier with a gastric resection, than he does with a vagotomy or combination of a vagotomy and gastro-enterostomy. In the more stable type of individual, with peptic ulcer and no pyloric obstructive symptoms, dramatic and gratifying results may ensue following supradiaphragmatic vagotomy. We are prone to be enthusiastic about the value of supradiaphragmatic vagotomy in certain selected patients with marginal ulcers following gastric resection or gastro-enterostomy.

Our experience in regard to other abdominal disease states treated by sympathectomy has been very limited. Three patients with chronic pancreatitis and persistent pain have been treated with bilateral resection of the sympathetic ganglia of D_9, D_{10}, D_{11}, D_{12}, and the splanchnic nerves. These three patients have had complete relief of their symptomatology. One patient with carcinoma of the pancreas, with the major complaint of pain, has been treated by similar bilateral operation with relief of symptoms. One patient having persistent pain following cholecystectomy was treated by unilateral sympathetic surgery with a good result. Another patient with unexplained persistent upper abdominal pain was treated by bilateral sympathectomy and a good response. In one incidence of a patient with severe tabetic crises, bilateral cordotomy was carried out without relief, but when this was followed by a bilateral splanchnicectomy, relief was obtained. Relief of abdominal pain was also obtained in another patient with major tabetic crises, but this syndrome was confused by the coincident presence of paresis and the patient subsequently required prefrontal lobotomy to control pain occurring at the operative site and other diffuse discomforts.

Our experience has been too limited to make any definite conclusions relative to the value of presacral neurectomy. In a few instances in which it has been carried out for dysmenorrhea, the results have not been satisfactory. The feeling of our gynecologists is, that the procedure is probably too extensive for the degree or seriousness of the complaints presented. It is felt that in at least 80 per cent of the dysmenorrheas, less radical procedures can achieve equally or more beneficial results. In three patients treated by presacral neurectomy, for persistent bladder pain, two showed definite improvement and one showed no benefit whatsoever. Our feeling is, that this field of autonomic nerve surgery needs much further definitive investigation. From the anatomical and physiological considerations involved, one would not predicate most value from this approach. In order to truly remove autonomic sensation from the internal genitalia and the lower urinary tract, it might well require transection of the lesser and least splanchnic nerves, first and second lumbar sympathetic ganglia and the sacral outflow of the parasympathetic system. Certainly this would appear to be too extensive surgery for anything other than persistent debilitating intractable pain. We have not tried the efficacy of vagotomy in the treatment of ulcerative colitis. In the main, the patients with this disease who presented themselves to us, appeared to have too far-advanced lesions to justify any valid trial of this approach. When presented with major bleeding, cachexia, and a fibrotic destruction of the colon, we considered that salvage could only be obtained by major resectional procedures. It is also felt that the autonomic nervous system imbalance may be only one of the less major factors in ulcerative colitis, and that therefore autonomic nerve surgery alone would probably constitute inadequate surgical therapy.

In summary, then, in regard to autonomic nerve surgery in relation to disease of the abdominal viscera we consider that our experiences in this aspect of surgery have been too limited for any definite conclusions. Vagotomy may be very beneficial in the treatment of marginal ulcer. Benefit of vagotomy in the peptic ulcer patients probably demands superb clinical judgment in the choice of patient candidates. Brief experience suggests that this approach can be of major value in regard to the symptoms of chronic pancreatitis, post-cholecystectomy dyskinesia, tabetic crises, and in intractable pain due to malignancy.

Autonomic Surgery for Diseases of the Thoracic Viscera

Let us now turn to a discussion of the problem of autonomic nerve surgery and disease syndromes of the thoracic viscera. The use of autonomic nerve surgery in regard to diseases in this area of the body constitute a relatively new venture. This fact must be emphasized because such probings into a new field must traverse many pitfalls before maturing. The application of sympathectomy particularly stellate ganglionectomy and the excision of the ganglia from D_1 through D_5 has experienced considerable application in regard to the control of intractable anginal pain. In about 80 per cent of patients the afferent pain fibers course through the sympathetic chain on the left. In the remaining 20 per cent of patients a major component of afferent innervation occurs on both the right and left sides. We have utilized the procedure in 15 patients with intractable angina without concomitant congenital cardiovascular disease. Five of these were treated with conjunctive rhizotomy of the first to fifth dorsal roots. In all 15 a unilateral approach was used and the results were imminently satisfactory in 14, while one had some persistence of pain and might well have deserved a bilateral procedure. Three other patients have been treated in whom there was a non-correctable advanced state of coarctation of the aorta with associated intractable angina pectorus. These three patients revealed far advanced arteriosclerotic changes of the entire aortic arch and descending thoracic aorta. All three achieved symptomatic relief from a left sympathectomy involving removal of the stellate ganglion and the entire thoracic sympathetic chain. One of these patients worked for three years subsequent to such surgery and died suddenly while working as a mechanic, probably from a painless vascular catastrophe. Two other patients with coarctation of the aorta in the upper age group with severe angina were treated by surgical correction of the coarctated area alone and achieved complete relief of their anginal syndrome.

We have had experience with only one patient with intractable paroxysmal auricular fibrillation undergoing stellectomy and upper dorsal sympathectomy. The result in this individual patient was completely disappointing.

It is most difficult to evaluate what role might be played by autonomic surgery in cor pulmonale. Sympathectomy alone in four patients with this syndrome proved to be essentially valueless. Two patients with this syndrome to a major extent were treated by a combination of stellectomy, upper dorsal sympathectomy, complete plexectomy, and pulmonary artery periarterial sympathectomy. There appeared to be some definite clinical improvement in these patients, and although the ultimate result was fatal, there appears to be a distinct potential in this procedure of increasing the longevity and comfort of the individual. Lesser degrees of cor pulmonale such as is presented in marked increase of pulmonary artery pressure in association with emphysema has been objectively decreased by surgical intervention.

There has been an interesting but small group of patients; namely, those with tetralogy of Fallot and associated absence of the pulmonary arteries. We have carried out complete excision of the parietal pleura and concomitant stellectomy and upper dorsal sympathectomy in hopes of increasing systemic-to-pulmonary artery collateral circulation. In three patients so treated, there has been dramatic improvement in the functional capacity and major lessening of the degree of cyanosis. We are still following this patient group who have undergone only unilateral surgery and are trying to define by their future course the need or value of a contralateral similar operative procedure.

There have been sporadic instances of the use of autonomic nerve surgery in an attempt to palliate the discomfort of irresectable malignancy. On four occasions, upper dorsal sympathectomy was carried out and found to be of no value in the palliation of carcinoma of the lung. On the other hand, on five occasions, high right vagotomy appeared to produce distinct palliation in the presence of irresectable bronchogenic carcinoma. This relief was mainly the relief of cough, but the resultant paralysis of the bronchus frequently required periodic bronchoscopic aspiration. We have not utilized left vagotomy in such patients for fear that a mild adjunct in palliation might produce major gastro-intestinal distress. On one occasion, a patient with a carcinoma of the thymus and multiple implants upon the ascending aorta, suffering from intractable pain was completely relieved of his symptoms by stellectomy and upper dorsal sympathectomy. It is interesting to note that this patient subsequently died suddenly from an apparently painless rupture of the ascending aorta. We do feel that autonomic nerve surgery should be considered if one explores an inoperable carcinoma of the lung if such patient is suffering from intractable cough or painful invasion of the adventitia of the aortic wall.

Sympathectomy has also been used as adjunctive surgery to relieve pain in the treatment of major aneurysms of the thoracic aorta. Whensoever a patient is operated upon for an aortic aneurysm associated with pain, the aneurysm should not only be wrapped with reactive diacetyl phosphate coated cellophane, but extensive dorsal sympathectomy should be utilized. This procedure seems to be of distinct value in patients in whom incomplete wrapping of the aneurysm is all that can be achieved.

We ventured rather expeditiously into the field of autonomic nerve surgery in the treatment of bronchial asthma. Many were the heartaches and much the knowledge achieved from these experiences. We hope soon to present a long-term follow-up of the patients treated in this manner. Our present conclusions are that there is a definite place for autonomic nerve surgery in selected instances in patients suffering from bronchial asthma. Duane Carr showed in a long-term follow-up of 6 patients who were totally adrenalin resistant, that sympathectomy produced gratifying results. We have not personally encountered any patients in whom preoperative tests proved the presence of true adrenalin resistance. The fact then that our experiences utilizing sympathectomy alone in bronchial asthma without beneficial results does not condemn the use of sympathectomy alone in patients who are truly adrenalin resistant. Bronchial asthma is again a disease with exacerbations and remissions. It is a disease involving multiple synergistic factors in its production. Its proper treatment demands extreme and diligent clinical investigation. The individual factors involved in the production of the disease must be analyzed in detail in regard to the relative role which each plays. It is often difficult to determine whether the psychological disturbance present in such patients is productive of, or resultant to, the bronchial asthmatic phenomena. Our long-term results indicate that with proper preoperative evaluation and selection of patients certain individuals demand surgical intervention for cure of their disease complex.

It is apparently a common phenomena in diseases involving a major component factor of autonomic nerve system disturbance that a focal area of irritation may produce an explosive uniform disturbance of the autonomic balance in the organ system involved. A great lesson has been taught us by patients who present the complication of ulceration in a bronchial stump due to suture material following lobectomy. These patients may return to us with the major complaint of cough due to bronchial irritation and severe bronchospastic behavior. With the removal of the suture material by bronchoscopic means and cauterization of the ulcer, complete relief of both cough and bronchospastic phenomena can be universally achieved. This clue led us to the premise that certain patients with bronchial asthma have trigger areas of pulmonary disease which play a major role in the bronchospasm of the patient. Cure of bronchial asthma has been achieved quite uniformly in patients whose history, physical findings, and objective tests prove that such a trigger area is present. Thus patients with bronchial asthma and solitary foci of pulmonary emphysema have obtained complete relief of symptoms by excision of the emphysematous focus and concomitant upper dorsal sympathectomy, pulmonary plexectomy, and periarterio sympathectomy. A similar phenomenon is noted in patients with localized pulmonary destruction of bronchiectatic type and true bronchial asthmatic seizures precipitated by such areas of infection. This experiment has been rather completely carried out. A group of patients with such a syndrome treated by lobectomy alone have persisted in their asthmatic behavior. A second group of patients treated by autonomic nerve surgery without complete control of the suppurative pulmonary factor have not shown long-term relief of symptoms. A group of patients in whom the surgical attack has been upon the two major factors together have yielded gratifying results. Removing the major focus of infection at a secondary operation following failure of autonomic surgery alone has resulted in social and economic rehabilitation.

Our present concept, then, of the role of surgery in regard to bronchial asthma, is that it is useful in a selected group of patients in whom surgery can attack the major factor, or factors, involved in production of the disease complex. A corollary to this is that patients in whom surgery can benefit the major factor, or factors, and medical treatment can eradicate other major factors, should and do achieve palliation. We are certain that patients with uncontrolled pulmonary suppuration of diffuse type are in no way candidates for surgical intervention. Major psychological disturbances, particularly narcotic addiction, contradict any hopeful attitude in regard to the surgical approach to this disease.

Having been educated and stimulated by our experience with bronchial asthma, we ventured to test a similar method of approach upon the problem of pulmonary emphysema. Several articles describing the details of our experiences in this line are now in press or in process of being written. Briefly, we consider that the etiology of pulmonary emphysema is due to the response of an improperly balanced pulmonary autonomic nervous system to the cumulative bombardment of various irritating and structural factors. Excessive tobacco in certain hypersensitive individuals can produce the initial areas of the disease; more commonly, persistent suppuration constitutes the irritating principal in the factor complex. Local damage productive of emphysema occurs in the pulmonary system. This local area by its trigger activity, in conjunction with the other irritants, plays a major role in the progress of the disease. It is predicated that the trigger area not only produces bronchospasm, but also pulmonary vascular spasm. Furthermore, the local area can, by compression or by distortion of adjacent bronchopulmonary areas, aid in the progress and spread of the disease. Our work has shown from an analysis of experience with over 200 patients, that bronchospasm in major degree, is present in 85 per cent of the patients. Various tests have been devised to prove the presence of such bronchospasm and to define the best medication capable of decreasing this aspect of the disease in the individual patient. The source of irritation, whether external or infectional, must be completely controlled. If the disease is localized sufficiently to prove the presence of a trigger area, this must be excised in conjunction with complete autonomic nerve surgery. In a few diffuse cases in younger individuals, relief has been obtained by complete autonomic nerve surgery alone. Much further experience must be obtained in regard to this aspect of the disease. It must be completely understood that not only the factors involved in production of the disease, but factors produced by the disease which enhance its progress must also be controlled. Thus, not only the local trigger area in the lung must be eradicated, but we must re-educate the respiratory muscles and, in particular, improve the action of the diaphragm.

From an appreciation of the need of the control of a multiplicity of factors in certain diseases, it is not surprising that the initial enthusiasm relative to celiac ganglionectomy for cystic fibrosis of the pancreas, experienced a rather acute deflation. One wonders whether this complete lack of enthusiasm for autonomic nerve surgery for this hopeless disease is justified. These are desperate cases and demand our continued interest. We have utilized this approach in two individuals. In one, the result has been completely disappointing. In both, there has been no increase in the enzyme content of the stool, or decrease in the total stool fat or nitrogen. However, in one there has been a dramatic, although probably temporary, improvement in regard to symptoms. Studying a group of these patients and particularly when one bronchoscopes them, it is very impressive that a most severe degree of bronchospasticity is present. The question, therefore, is raised for future evaluation, whether there might be some value in combining complete pulmonary denervation with celiac ganglionectomy, and possibly in addition producing an arteriovenous fistula in the patient's pancreas.

Another and, as yet, totally undefined aspect of autonomic nerve surgery in regard to its value, is the effect of such surgery upon the growth of limbs. In two instances such surgery has been carried out in patients with shortened limb, due to poliomyelitis. The results after a six-year follow-up, have been most disappointing. We have, under observation, a group of seven children who have had stellate ganglionectomy and upper dorsal sympathectomy, ranging from the ages of 2 to 10 years. These patients were operated upon because of major disease of the thoracic viscera. We will watch with interest the effects upon the growth of the upper extremity.

Summary and Conclusions

The author has attempted to eradicate some of the prevalent confusion in regard to the function and surgery of the human autonomic nervous system. This is a vast field and invades the territory of the anatomist, physiologist, pharmacologist, internist, surgeon and psychiatrist. The confusion in regard to this realm of human physiology is felt to be due to five major factors. These are, (1) improper attempts to compare or parallel the function of the autonomic nervous system of one species with that of another species, whether human or animal; (2) there appears to be a distinct difference in individuals of the human species in regard to the degree with which the autonomic nervous system is under the subconscious and conscious cortical control; (3) inadequate appreciation of the multiplicity of factors involved in certain disease complexes, has led us to condemn autonomic nerve surgery, when other major factors involved in the disease are not controlled; (4) the period of autonomic nerve surgery prior to World War II was so hampered by incomplete surgical attack and inadequate knowledge of the disease syndromes, that only confusion could result; (5) anatomical variations of the human autonomic nervous system.

The anatomy and physiology of the autonomic nervous system has been briefly reviewed. The term "autonomic," itself, leads to confusion. It would be preferable if we differentiated the two nervous systems as (voluntary) "external environmental" and the (autonomic) "internal environmental" nervous system.

Experience has shown us that a vast unexplored field will be opened up with a better appreciation of the conscious manifestations of autonomic nerve irritation and dysfunction. Every patient undergoing surgery for diseases which, at present, are considered to be asymptomatic or minimally symptomatic, should undergo a complete analysis of vague and bizarre symptoms prior to such surgical intervention. A follow-up study in regard to the changes produced in such symptomatology, by extirpative surgery or autonomic nerve surgery, will increase our knowledge in regard to this important aspect of the problem. One cannot help but wonder what the physician of the 21st century will record in regard to our over-all knowledge of symptomatology. This broader concept of an eye to the future is of particular importance in regard to all patients presenting bizarre symptomatology. Only too often have we encountered patients with serious organic pathology whose bizarre symptomatology resulted in their initial misdirection into psychiatric and psychosomatic diagnoses and therapy.

Rather than a summary of the literature in regard to recent advances in autonomic nerve surgery, the author has preferred to present a quite comprehensive over-all experience in this field by the surgeons in Emory University, in the Department of Dr. D. C. Elkin.

It is hoped that this review of experience involving more than 1400 patients undergoing autonomic nerve operative procedures, should eventuate in a broader understanding of the problem. Our present conclusions are:

1) The present confusion existent in regard to surgery of the autonomic nervous system is due to five basic causes which have been presented and discussed.
2) The autonomic nervous system might better be named the "internal environmental nervous system."
3) The conscious component of autonomic nerve activity exists and deserves major future attention.
4) The concept of multiple coordinative or synergistic factors in the production of certain disease syndromes is valid and useful.
5) The therapeutic value of autonomic nerve surgery should parallel:

a) The completeness of the denervation procedure
b) The role which autonomic imbalance plays in the synergistic production of a specific syndrome
c) The susceptibility of other major factors to medical or surgical control
d) The degree of completeness of medical understanding of the specific disease
e) The physicians' appreciation of the need for individual evaluation of each patient and the potential variabilities of autonomic nerve behavior
f) The selection of patients for surgery with regard to each patient's individual personality, innate desires, and disease.

6) We must maintain a constructively critical attitude to this rapidly developing field of therapeutics.

BIBLIOGRAPHY

1. Best, C. H. and Taylor, N. B., The Physiological Basis of Medical Practice, Williams and Wilkins Co., 5th Edition, p. 1072
2. Dragstedt, L. R., Supradiaphragmatic Section of the Vagus Nerves in the Treatment of Gastric Ulcer Gastroenterology, 1944, **3**, p. 450
3. Cannon, W. B., The Autonomic Nervous System: an Interpretation, Lancet, 1930, I, p. 1109

THE RELATIVE POSITION OF THE SPECIALIST, THE GENERAL PRACTITIONER AND THE PUBLIC HEALTH OFFICER IN BRITAIN[1]

SIR ALLEN DALEY, M.D., F.R.C.P.[2]

The common denominator of these three groups is that everyone must be a "Registered Medical Practitioner," and, as I find that term is not well understood here, I will try to explain it. It applies to men and women who are registered with the General Medical Council, a body set up by Parliament about a hundred years ago for the purpose of enabling the public to distinguish between practitioners of medicine who had been properly trained and proved their competence by examination, and those who had not. It is only registered medical practitioners who can sign death certificates, order dangerous drugs, or hold medical appointments under public bodies including the hospital, general practitioner, and public health sections of the National Health Service. Though there are a few osteopaths, nature curers, Christian Science practitioners, and other non-registered medical practitioners in Britain, they are much less common than here. The General Medical Council is not itself an examining body. It consists of a representative of each of the universities and other examining bodies together with two or three laymen. It is also the disciplinary body for the profession and hears complaints of unprofessional conduct. It does *not*, however, concern itself with allegations of professional negligence or malpractice. That is a matter for the ordinary civil courts or the special machinery set up under the National Health Service Act. The General Medical Council can strike off its roll the name of anyone judged guilty of unprofessional conduct "in an infamous respect." A registered medical practitioner can practice anywhere in the British Isles or in the Colonial Empire and, by reciprocal arrangements, in the British Dominions, though, curiously, not in some Provinces of Canada. There is no "State Licensure." The General

---

[1] Address given at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, on April 30th, 1952. (Faculty Transactions, 1952)

[2] Associate Health Officer, City of Baltimore; formerly Medical Officer of Health, London County Council.

Medical Council also prepares, revises and publishes the British Pharmacopoeia. The Council determines the minimum requirements for (a) general education before a medical student can be accepted and (b) premedical, preclinical and clinical training. It accepts the examination results of the approved examining bodies but periodically sends its representatives to be present at the examinations. In England and Wales the examining bodies are the University of London and the ten provincial universities with medical schools. The University of London has twelve undergraduate medical schools; the provincial universities, one medical school each. The minimum training schedule after examinations have been passed in chemistry, physics and biology is two years in anatomy, physiology and biochemistry and three years clinical work. There must be an "external" examiner from another medical school and to whom the candidate is not known, associated with examination in every subject. The twelve medical schools in London present their students for the university examination and cannot hold qualifying examinations themselves. On passing the university examination, the candidate pays a small fee to the General Medical Council and becomes a registered medical practitioner. The degree given at these qualifying university examinations is not, however, the M.D. but the *M.B.* i.e. Bachelor of Medicine generally associated also with *B.S.* or *B.CH.* Bachelor of Surgery. The *M.D.* is given only as the result of a further examination of high standard for which original research work is normally required. The M.B. suffices for general practice and only a small percentage proceed to the M.D. In addition to the university examinations, there are two other examining, but not training, bodies (1) the Conjoint Board of the Royal Colleges of Physicians and Surgeons and (2) the Society of Apothecaries. They give respectively the *Diplomas* of M.R.C.S., L.R.C.P., Member of the Royal College of Surgeons and Licentiate of the Royal College of Physicians and the L.S.A., Licentiate of the Society of Apothecaries. The training curriculum is the same as for a university degree but some think their examination standards are not so high. Those who pass their examinations are registered by the General Medical Council in the same way as are university graduates and become "registered medical practitioners." Often a man who has failed his university examinations will sit for the diploma examinations so that he can begin to earn his living. Many highly successful general practitioners have a diploma only and not a degree. All registered medical practitioners, however, assume, and are given in conversation and correspondence, the courtesy title of "doctor" though only the few with the degree of M.D. are, strictly speaking, entitled to it. There is one curious exception. Surgeons of any type and including ophthalmic surgeons, ear, nose and throat surgeons, and gynaecologists, divest themselves of the title of "doctor" even though they have the degree of M.D. and become plain "Mr." "Mrs." or "Miss" as soon as they are established in a surgical specialty.

There is great pressure on the medical schools. There are, over all, more than three applicants for every vacancy, and some of the popular schools have ten applicants for each place. About 20% of medical undergraduates are women.

It would be convenient if I now describe how general practice, a specialty, and public health are entered, and explain any differences which have followed the introduction of the National Health Service four years ago.

GENERAL PRACTICE

Occasionally a man would go into general practice immediately after qualification and without doing any internship. This was regarded as very unsatisfactory and the General Medical Council have made a new rule which becomes operative next year to the effect that the passing of the qualifying examination only entitles him to practice in a hospital under supervision and, before entering upon any type of independent practice, he must do a further year as an interne in an approved hospital. The medical schools are now actively engaged in determining which non-teaching hospitals can be regarded as suitable for the further training of those of their students for whom they cannot find internships in the teaching hospital itself, and how the time should be allocated between medicine, surgery and obstetrics. It is unlikely that there will be a further examination at the end of the year's work as an interne. A certificate from his chiefs of diligent application to his work will suffice. The interne will receive free board and lodging and a small salary.

But, to revert to the pre-1948 position, the usual procedure was for a man to work for from 6 months up to 2, or even 3 years, as an interne. These posts change, as a rule, every 6 months and he would endeavour to obtain varied experience. Only the best students were given internships at their teaching hospitals and only those likely to become specialists were retained there for more than a year. Most of those aiming at general practice went to non-teaching hospitals—voluntary or municipal. The payment of internes varied from nothing in the teaching hospitals, where sometimes even board and lodging were charged for, to £150 a year plus free board and lodging in the non-teaching. In comparing British rates of pay in the real value of money i.e. purchasing power, a simple working rule is to multiply the pound by 6. A salary of £100 a year is the equivalent of about $600 on this basis. In a year or so after becoming a registered medical practitioner he would (1) look out for an "assistancy with a view to partnership" in a general practice or (2) buy the practice of a deceased practitioner, or a share of a growing practice or of one where the practitioner contemplated retirement or (3) "squat" i.e. put out his professional plate in a district where he thought he could build up a practice, e.g. in a growing suburb. It is much commoner in Britain than here for general practitioners to work in partnerships. A two man partnership is very common and there are many partnerships of six to eight. Until 1948, when it was prohibited by law, a doctor's main asset was the selling value of his practice. He would rely on the money he would get for his practice to keep him in his old age or to provide for his widow. In Britain many general practitioners have their professional "offices" in the houses where they live though they may, also, have outlying "offices." It is a curious fact that patients become attached to a particular "office" or "surgery" as we call them as much as to the doctor himself and, when a man bought a practice and took over the former doctor's house or surgery he could rely on the vast majority of the former patients transferring to him. The usual charge made for a practice was "two years purchase" on the gross takings. It is common for practice expenses to be 38.7% of the gross takings. A young man buying a practice had therefore to have, or borrow, a substantial sum of money. When the Government, for reasons which are not quite clear though they are associated with a desire to ensure a better distribution of doctors. and to avoid enhancing the value of practices, as would have occurred when 95% of the population went on to doctors' lists and their medical care was paid for by capitation from public funds, then set aside the large sum of £66,000,000 to compensate doctors for the loss of the "good will" of their practices. This money is being paid out in the form of a pension when he retires or a lump sum if he dies.

In the new régime. there is no interference whatsoever if a man desires to set up in *private* practice. He can go anywhere and try his luck. But the National Health Service has hit private general practice much more than private specialist practice and very few general practitioners can earn a living unless they are in the National Health Service.

The Government have appointed a small "General Practice Committee" comprising general practitioners, selected after consultation with the British Medical Association and one lawyer. The Chairman is whole-time; the rest are part-time and paid on a sessional basis. This Committee has divided the country into (a) areas which are over-doctored or "closed" areas and (b) areas which are under-doctored. There are, also, certain intermediate groupings. No one is allowed to set up in practice *under the National Health Service* without the consent of this Committee. Normally, they will only allow a new entrant in a "closed" area if it is a case of a son succeeding his father, or a nephew an uncle, or an assistant who has been there a long time being taken into partnership. If a man wishes to set up anywhere other than in a "closed" area, permission is given automatically though an effort is made to persuade him to start in an under-doctored area.

Generally, a partnership will look out for a suitable colleague and put his name forward, often after a spell as a whole-time salaried assistant to see if they get on well together. On the occurrence of a death vacancy, it is generally advertised though it is interesting to note that sometimes in such cases, the other doctors of the areas will suggest that the vacancy needn't be filled as they can easily absorb the dead doctor's patients in existing practices.

The country is divided into 145 areas for the general medical and dental practice part of the National Health Service and each has a local medical committee of doctors only, who advise on all professional matters. They are associated with the selection of new doctors for their area. Special "inducement" payments in the form of an annual salary in addition to the capitation payments are made to attract people to unpopular or difficult areas. Rural practitioners, also, receive special mileage payments and as they do their own dispensing they get additional remuneration for that. When a man starts practice anywhere he can apply for a "fixed annual payment" generally £300 a year. It is stopped, however, after 2 or 3 years, if he has by then either got a substantial number of people on his list or has failed to make substantial progress in building up a list. The normal method of payment on which the profession has insisted is by capitation, *not* salary.

The total number of general practitioners working in the scheme is just over 20,000. The average number on doctors' lists is about 2,500 patients. The maximum number is 4,000 but if he has a whole time assistant he can take another 2,400. The general opinion is that these numbers are too high for first class work to be done.

Specialists

Before the new scheme it was difficult for a young man, however bright, to become a successful consultant unless he had enough money behind him to augment his earnings while he was being trained and until he became established, which, often, was not until he was in his mid-thirties. The normal progression was: (1) internship at his teaching hospital, (2) assistant resident, (3) then resident at a teaching hospital, (4) passing the examination for the appropriate post-graduate diploma, (5) obtaining an advertised honorary visiting post in a hospital and (6) taking an office on the street where consultants practice: in London, Harley Street or its immediate vicinity. At point (5) however, he might apply for a whole-time specialist post either in a non-teaching municipal hospital or in a university department.

We do not have in Britain what are called here, "specialty boards." Competence in the specialties is indicated by the possession of post-graduate diplomas awarded generally by the Royal Medical Colleges of which there are three in England, three in Scotland and two in Ireland, and in some subjects by the Conjoint Board. Also, most of the universities have a degree of Master of Surgery. We use the term "Physician" for what you call an "internist." The oldest Royal College is the Royal College of Physicians.

Hospitals making appointments as Physicians only accept as applicants those who are members or fellows of the Royal College of Physicians. The examination for membership of the College is of very high standard and the percentage who pass is generally below twenty. About 30 members of the College are selected every year at a meeting of the Fellows and elected to the Fellowship. The constitution of the Royal College of Obstetricians and Gynaecologists is similar and candidates for hospital posts must have the diplomas of M.R.C.O.G. or F.R.C.O.G. With regard to surgery, the *membership* of this College is not a specialist qualification and the fellowship, which corresponds to membership of the other two colleges is awarded after a stiff examination. The F.R.C.S. is a prerequisite for obtaining a post as a hospital surgeon. There are special diplomas in radiology, anaesthesia, clinical pathology, child health, etc., but they do not have the standing of the M.R.C.P., M.R.C. O G., or F.R C.S.

Before 1948 each Hospital Board set up a selection committee of its own medical staff, and laymen from its Governing Body, to consider applicants for positions as specialists and there was complaint that the large teaching hospitals gave too great preference to their own ex-students. To try to prevent this "in-breeding," every hospital vacancy for a specialist must now be advertised and the interviewing and selection committee of seven, including one or two laymen, must contain specialists who are not attached to the hospital concerned. Under the new scheme, all interne and resident appointments are paid. The pay increases year by year, and after the first 2 or 3 of the 5 years of resident appointments, needed for a specialist training, even a married man can live on it if he is careful. Before 1948, a young specialist on finishing his resident posts, being appointed to the visiting staff and starting in consultant practice, received no pay for his hospital work and he was regarded as lucky if, for the first year or two, he made enough to pay the rent of his consulting rooms. All hospital visiting and consulting staffs are now paid. The pay is based on the thesis that he will attain the rank of specialist at the age of 32 years or soon after. The pay increases automatically year by year for about 10 years. All types of specialist receive the same scales of payment. The anaesthetist gets the same pay as the surgeon. A specialist may be whole-time in the service or part-time. If the latter, he is paid proportionately to the time he gives to hospital work but cannot be paid for more than 9/11ths of full time. The pay for which, however, is 9½/11ths of the full time salary.

There is an interesting system of "merit" awards. A committee of very senior specialists has been set up to consider the professional standing of the hospital specialists. They have selected 3% in each specialty for a merit award A, 10% for merit award B, and 20% for merit award C. Those with a merit A award receive an addition which is nearly as much as the basic salary at its maximum (£2,500 a year for the award, £2,750 basic salary) and the total is more than the salary of a cabinet minister. Up to 1948 the salary of a whole-time University Professor in a clinical subject was £2,500. A merit B award amounts to £1,500 and a C to £500. The above are the whole-time rates but the majority of specialists are part-time and also engage in private practice, and they get the appropriate proportion of the merit award. Most hospitals, even though they are now owned and maintained by the Government, have private beds and the patients in them can be charged fees by the specialists. The income tax regulations are weighted in favor of the part-time as compared with the whole-time doctor. All specialists posts whether whole or part-time, are pensionable and give entitlement to 6 weeks paid annual holiday

PUBLIC HEALTH

A few words will suffice to describe entrance to the public health service. By law, no one can be appointed medical officer of health (Health Officer) for a population of more than 50,000 unless he possesses a Diploma in Public Health registered with the General Medical Council. The General Medical Council prescribes the curriculum which occupies one academic year and inspects the examinations. It is unusual for an entrant to the public health service to have had less than 3 years general experience after graduation. This is generally spent in hospital posts. Experience is acquired in one or more of: communicable diseases, obstetrics, paediatrics, tuberculosis, venereal disease, etc. Often a post in pathology or bacteriology is included. Most try to get experience of general practice.

The first few years after appointment to the health service are usually spent in maternity and child welfare and school health work, with such epidemiology and work in the environmental field, medical care programmes, etc., as come their way. Gradually, they acquire administrative experience and apply for posts as health officer of a small community. They work their way up the ladder of promotion and their final position depends on their ability, the impression they make on their colleagues and appointing committees and, to some extent, on luck.

No post is ever filled by a political appointee. As vacancies occur, they are advertised and any attempt to bring non-professional or political influence to bear, disqualifies a candidate. No medical officer of health can be discharged without the consent of the Ministry of Health. All whole-time positions in the health service are pensionable and pension rights continue when a man transfers to any other post, national, university or local authority.

Until the advent of the National Health Service, public health attracted good quality doctors though for some years there had been a tendency to recruit into it a number, particularly women, who were primarily interested in clinic work among children and had no desire to become health officers. In those days, as I have explained, capital was needed to buy a general practice or to keep oneself and possibly one's family for many years, while training for a clinical specialism on very small pay. Public health needed no capital beyond that necessary to obtain the Diploma in Public Health and a salaried appointment, sufficient for a married man, was obtainable within three years of graduation. The ultimate financial prospects also compared not unfavourably with those of general practice and of specialist practice also, if one excluded the few at the very top. The position has now changed and the good types who formerly went in for public health can now do almost as well, at the beginning, on the hospital side and have much better ultimate prospects than in public health. The long term effect of this remains to be seen.

Relative Positions

We are now, with this background, in a better position to consider the relative positions of the three great branches of medical work. Perhaps the first thing I should do is to quote from the recent report of a committee of the British Medical Association on "General Practice and the Training of the General Practitioner" (1). Its Chairman was Sir Henry Cohen, M.D., F.R.C.P. "The Committee considers that the traditional distinction in status and prestige between general practice on the one hand and any and every specialty on the other is wrong. The adequate pursuit of many specialties requires no higher ability, industry, zeal and personality than general practice; indeed, some require less."

Again, this Committee says, "General practice demands a study of "the whole man." It is a special branch of practice with functions which in their entirety bring ultimately to the individual patient the benefit of the resources of all the specialties."

There has been with us criticism of the training of undergraduates in that it is almost, if not entirely, in the hands of specialists, that there is undue emphasis on the diagnosis of rarer types of disease and that the common ailments of children and the aged which form much of the work of a general practice receive scant attention. To rectify this some schools arrange for general practitioners to give a few lectures to the students and the University of Edinburgh has a general practice attached to the school. With us, a man, accustomed as an interne or assistant resident, to have at his back efficient pathological and X-ray departments, feels completely at sea when he enters general practice and has to rely almost entirely on what he can see, hear, and feel.

Efforts are being made to ensure that patients can have ready access to hospital out-patient departments but all parts of the country are not yet covered for this purpose. Any practitioner can send his patients to the out-patient department of a hospital and will receive a full report but some hospitals still have a rule that the laboratory and X-ray services can only be used on the order of one of their own staff.

Dr. Joseph S. Collings (2) in a recent report on general practice in England today examined practices in (a) industrial areas (b) urban areas and (c) rural areas. He found much that was unsatisfactory. He said, "General practice is now worse in close proximity to large hospital and clinical centres and improves in both scope and quality almost in proportion to the distance away from those centres" and "Rural practice represents the last outpost of real family doctoring." He refers to the emphasis given in the new National Health Act to hospital and specialist services. We have in Britain many small Cottage Hospitals staffed by the local general practitioners but with visiting specialists on call. A certain amount of surgery was done in them by men who were primarily general practitioners but who had a diploma in surgery. Until fairly recently a man in general practice could develop a special interest in some branch of work, obtain the necessary academic qualifications, secure a position on the visiting staff of his local hospital, ultimately give up i.e. sell, his general practice and confine himself to specialist and consulting work. With the new uniform system of advertising vacancies for specialists and the selection being made by committees containing outside senior men, such posts are now almost universally filled by young men who have been trained at teaching schools and have never been in general practice. As Collings says: "The G.P. Surgeon is the Chief Target in what I can term the "attack" on general practice and there is a tendency to extend the attack against him into other provinces of the G.P.'s activities." He refers also to the growth of specialisms involving whole age groups: paediatrics within the last 20 years and now geriatrics.

He says "The current growth of paediatrics and geriatrics represents another attempt to compensate for deficiencies in general practice in terms of more specialist and hospital care. This trend has been going on for a long time, but, if it continues it is bound to result in. . .ultimately, the elimination of the general practitioner as a responsible person." Collings has dealt faithfully, some think too faithfully and dispute his data, with the unsatisfactory trends in general practice. He is careful, however, to point out that these defects existed before the National Health Service Act "which has done nothing immediately or directly to disturb the structure of general practice." In fact, the new provision by which a general practitioner can call out a specialist to see a patient at home does tend to bring G.P.'s and specialists into closer contact.

All who give thought to the problems of general practice, whether laymen, specialists, public health people or general practitioners themselves really believe that the concept of the family doctor, for the general care of the health of the whole family, must be our aim. But he must have behind him the advice of specialists of all kinds including the public health specialist. Such, indeed, is the theory of the British National Health Service but, mainly as a result of trends which have developed over the years, and which tend, for various reasons, to sidetrack the general practitioner, he seems to be losing his proper place. This is an age of increasing specialism and of increasing knowledge of the public about medical matters. If they, or their relations, are seriously ill they are not satisfied unless they see a specialist.

In Britain a specialist will not see a patient privately unless he is introduced by a general practitioner and an increasing number of hospitals will not admit anyone to their out-patient clinics unless they bring a note from their own doctor. If the illness is alleged to be urgent, the patient is seen in the casualty department and the case admitted or referred to his own doctor after first aid treatment as the case requires. Every effort is being made to associate general practitioners with hospital work. Sometimes, a Hospital Board will attempt to close a G.P. hospital, but it always meets with such strenuous opposition that further attempts are unlikely.

The Department of Health for Scotland has just published a report (3) entitled "The General Practitioner and the Hospital Service" which recommends: "The increased employment of general practitioners as members of hospital staffs must be viewed in terms of a recasting of the staffing structure as a whole. The new structure should envisage an establishment embracing doctors wholly engaged in specialist practice, doctors wholly engaged in training for specialist practice, doctors engaged partly in general and partly in specialist practice, and house officers (internes)." This, if adopted, will correct the recent tendency to bar the way from general to specialist practice. An interesting series of articles on how men a generation ago found their way into various types of practice may be read in the last Education number of the British Medical Journal (4). Because of the general feeling that all is not well with general practice the Central Health Services Council has set up a Committee, of which I am a member, on "General Practice" with a view to examining the whole problem and endeavouring to re-instate the general practitioner as the backbone of the medical services of the country and ensure that he has proper facilities for carrying on his work.

More and more attention is being given to means by which a G.P.'s knowledge may be kept up to date, by refresher courses, paid for by the Government, regular ward rounds at local hospitals, etc. Despite the report of the "Spens Committee" (5) on the remuneration of general practitioners which emphasised the importance of improving financial "prospects in general practice in order to render this branch of medicine sufficiently attractive to prevent all the abler men endeavouring to enter specialist practice," it is only within the past few weeks that, as a result of arbitration, the remuneration of general practitioners has reached a reasonable level and, even now, specialism offers glittering prizes for the chosen few.

A recent trouble we have had in the hospital service has been due to the fact that at the time the scheme began there were in office a large number of "residents" and "assistant residents." Many were "veterans" taking advantage of the Government's post war training scheme. It was soon realized that many more were being trained as specialists than the country could afford to pay for as specialists in the national hospital service or even than the patients needed. This is despite the fact that the total number of specialist posts has increased greatly since 1948. A somewhat drastic "weeding out" of the "residents" is in progress so as to match the number of trainees more nearly with the number of probable vacancies for specialists in the next few years.

With regard to public health, the relationship of public health officers to both general practitioners and specialists is good. In many ways the health officers act as the bridge between themselves and other departments and the other two branches of the service—the general practitioners and the hospital service. British health departments have closer contact with the treatment services than in this country; possibly because for many years they administered hospital services and provided treatment for school children. They still provide ambulance services for the hospitals; a domiciliary midwifery scheme, a home bedside nursing service, a domestic help service and general after care services.

It is recognised that the time is coming when the general practitioner service will take over some of the clinic work now done by whole-time assistant health officers. A section of the National Health Service Act requires local Health Departments to provide "Health Centres" where a group of say six doctors will be provided with accommodation and with nursing and secretarial assistance. The G.P.s will receive capitation fees according to the number on their lists and will pay a small rent to the Health Department for the accommodation and the services provided. The usual clinic services for infants and school children will be accommodated separately in the same building and it is expected that say two of the six doctors will be specially interested in obstetrics, do the midwifery of the neighbourhood and take the pre-natal clinics; another two would be interested in paediatrics and would take the infant welfare clinics and do the inspections of school children. Several Health Centres on these lines are about to be opened, one in London.

But health centres containing group practices are in the experimental stage and we are feeling our way. One new centre at Corby which is at some distance from a hospital is to concentrate on providing in the building from which the doctors practice, first class diagnostic facilities. Also, specialists will attend periodically. Health officers are taking a close interest in these experiments.

To some extent, the work of Health Officers is contracting but in others expanding. They have plenty of scope if they study the disease patterns in their locality and remember that with the advance of medical knowledge further preventive measures will, undoubtedly, be discovered and can be applied. Even now, "after care" offers a wide scope, e.g. in Cardiff a scheme has been running successfully for some time under which public health nurses in co-operation with the general practitioners and hospital specialists supervise in their homes cases of diabetes and of gastric and duodenal ulcer. It should be an axiom that no highly and expensively trained person should spend his time on duties which can be done equally well by someone with less, but adequate, training. Health Departments can help to relieve the load on doctors by health education and, as mentioned earlier, by providing nursing and clerical assistance at Health Centres.

CONCLUSIONS AND SUMMARY

Let me now try briefly to sum up:

(1) Everyone in Britain pays at least lip service to the key value of the general practitioner.

(2) His functions tend to be curtailed and his status lowered. This trend has been there for many years and we are anxious to re-instate him to his former position. This is probably the outstanding problem in British medicine. It is not caused by the new National Health Service. Its roots go much deeper, but the existence of the Service has focussed attention on it.

(3) The conditions under which many general practitioners work are unsatisfactory.

(4) Medical practice is often the least satisfactory in the neighbourhood of a great hospital.

(5) This is because many of his patients insist on going, or being sent to, the hospital and the general practitioner tends to lose touch with his serious cases. Newspaper publicity about hospitals and specialists undermines faith in the competence of the G.P.

(6) Giving access of the G.P. to his patients while in hospital is not an adequate answer. Full reports to the G.P. about his patients are essential. But even this is not enough. The G.P. must be given some definite place in the hospital hierarchy.

(7) Definite schemes for keeping the knowledge of a G.P. up to date by refresher courses of various kinds are essential.

(8) What practitioners most need in Britain is more leisure to enable them to keep up to date. The recent substantial increase in their remuneration will help in this, as a man need not have so many on his list to earn a reasonable living.

(9) Group practice is being developed, where up to six doctors work in partnership. In some

cases accommodation and clerical and nursing help are provided for a small charge by Health Departments.

(10) General practitioner hospitals are advocated as adjuncts of hospitals staffed by specialists.

(11) The specialists in the British service have little of which to complain. Some, in other branches of medical work, indeed, say they are the pampered section.

(12) G.P.s can now get a visit of a specialist to a patient's home under the State service. This tends to bring G.P.s and specialists closer together.

(13) The public health service, still with multifarious duties, is linked with both the G.P. and specialist services. The cost of hospital services to the public purse is crippling and increasing attention must be paid to prevention of illness and treating as many as possible at home.

(14) The G.P. paid on a capitation basis regards the health officer as a close ally; supports all measures of prevention and gladly avails himself of the nursing and other services which the Health Department supplies.

I have touched only lightly or not at all on some of the problems which beset us. There is an earnest desire to make the new scheme, which is still very new and more costly than most people expected, prove of real benefit to our patients, without doing any real harm to the profession of medicine. The leaders of all branches of the profession are closely associated with the administration of the scheme and through the Central Health Services Council have direct access to the Minister and, through its annual reports, to the public. Fortunately, no branch of the profession is trying to better itself at the expense of another. Through the British Medical Association, balanced decisions can be reached when different interests appear to be in conflict. Everyone now is alive to the importance of raising the status of the G.P., and this is, perhaps, the greatest and most difficult problem now facing us.

BIBLIOGRAPHY

1. General Practice and the Training of the General Practitioner. The report of a Committee of the British Medical Association. London 1950
2. General Practice in England Today: A Reconnaissance. Joseph S. Collings: The Lancet: March 25, 1950
3. The General Practitioner and the Hospital Service. Department of Health for Scotland: The Scottish Health Services Council. H.M.S.D. 1952
4. British Medical Journal: August 25, 1951
5. Report of the Inter-Departmental Committee on the Remuneration of General Practitioners: 1946: H.M.S.D. Cmd 6910

CLINICAL PATHOLOGICAL CONFERENCE*

T. NELSON CAREY, M.D.† AND C. GARDNER WARNER, M.D.‡

W. B.; colored male, age: 24; autopsy #5862; chart #31427. Admitted: January 6, 1950; Died: January 23, 1950.

CLINICAL HISTORY

This patient was a 24 year old porter who was admitted to the University Hospital on January 6, 1950, with complaints of drowsiness and disturbances of vision. His illness is said to have started in September, 1949, when he became so sleepy that he could not work efficiently. Sleepiness came on at any time and persisted until his admission to the hospital. He stopped work about

---

* Presented at the Annual Meeting of the Medical and Chirurgical Faculty on April 29, 1952, by the University of Maryland, School of Medicine (Transactions 1952).

† Professor of Clinical Medicine, School of Medicine, The University of Maryland.

‡ Associate Professor of Pathology, School of Medicine, The University of Maryland.

December 29, 1949, and at the same time began to vomit and complain of blurring of his vision in one eye. Nocturia was described for about two months, and his appetite had been failing for the same time.

The past history was negative with the exception of the recognition of hypertension in 1942, when he was refused admission to the Army. There was no history of tonsillitis, scarlet fever, or urinary tract infection.

Physical examination was recorded as follows: The patient is a well developed, slightly undernourished Negro male of 24, who is lying flat in bed in a lethargic state. He responds sluggishly to questioning, but dozes off during examination. The breath is foul, but there is no odor of ammonia. The skin is dry and turgor is poor. There is no striking evidence of weight loss and muscular development is good. There is no lymphadenopathy. The hair and scalp are negative. The pupils react and ocular movements are normal. There is slight periorbital edema. Ophthalmoscopic examination reveals normal nerve heads. The retinal arteries are markedly tortuous and constricted, with many flame shaped hemorrhages of varying sizes. There are a number of scattered yellowish to white fluffy exudates. The nasal septum is in the midline. The sinuses transilluminate well. The oral mucous membranes are dry. The teeth are stained, there is moderate pyorrhea. The tonsils are small. The trachea is in the midline. The thyroid is not palpable and there is no cervical adenopathy. The chest expands well and respiratory rate and rhythm are normal. The lungs are resonant, and breath sounds are vesicular. A moderate number of medium rales are audible over both lower lobes. The cardiac outline is normal. The sounds are regular with rate of 100. There is a gallop at the apex and the first sound is followed by a systolic murmur which is not transmitted. The second aortic sound is accentuated and split. Blood pressure is 260/160. The abdomen is soft. The liver edge is palpable about one inch below the costal margin. The kidneys and spleen cannot be felt. Genitalia are normal and rectal examination is negative with a small, non-tender prostate gland. The extremities are negative with no evident thickening of peripheral arteries.

Throughout his stay in the hospital, the patient's urine showed constant specific gravity varying between 1.010 and 1.012. Large amounts of protein were present in all specimens, estimated at 8 grams per liter. Microscopic hematuria was present in half the specimens examined. Hyaline and granular casts were also described. The stool contained a trace of blood on chemical examination. Phenolsulfonphthalein excretion was less than 5% in one hour. Hemoglobin was 10.8 gm. or 76%. The leukocyte count was 8,100 with a normal differential formula.

On the morning after admission, blood urea nitrogen was 150 mgm. Blood sugar was 88 mgm. and the CO_2 combining power was 49 vol. per cent, or 22 mEq. per liter. The serum chloride was 76 mEq. The plasma protein was normal. On January 10, 1950 the blood urea nitrogen had risen to 164 mgm. and the serum chloride was further depressed to 63 mEq. The blood CO_2 combining power had risen to 58 vol. per cent, probably because of continued vomiting.

After intravenous administration of sodium chloride and glucose, the blood urea nitrogen fell to 170 mgm., but later rose to 188, and terminally to 260 mgm. The serum sodium, which was depressed to 109 mEq. on January 12, rose to 123 on January 21. However, the serum potassium, which was 3 mEq. on January 10, rose terminally to 6.9 on January 21.

X-ray of the chest, which was taken on January 6, 1950, was normal. There was no demonstrable cardiac enlargement. The electrocardiogram showed some nonspecific abnormalities including depression and arching of the ST segment in Lead 2, with late inversion of the T waves in Leads 1, 2 and 3.

The patient continued to go downhill in spite of therapy. An attempt was made to give him the so-called Kempner rice, fruit, sugar diet, but this was not tolerated because of continued vomiting. Intravenous feeding with glucose was continued until death with efforts at correcting uremia and electrolyte balance by administration of sodium chloride. The patient died on January 23, 1950 at 4:30 A.M., after continued stupor developing into coma. Terminally, uremic frost was observed.

Dr. T. Nelson Carey: The patient whom we are to discuss this morning does not present a very obscure clinical picture but serves quite well as a teaching problem.

The man was a Negro of twenty-four who was admitted to the University Hospital, January 6, 1950 and died January 23. He was a porter and at the time of admission complained of drowsiness with some disturbance of vision.

I believe that we all agree that this patient was uremic and that he died of that abnormality. Uremia may be defined as a symptom complex or syndrome which arises from retention within the body of those constituents which are normally excreted in the urine. For years there have been many attempts to explain the uremic state. It is obviously not caused by retention of urea, as this material is almost completely harmless. Some uremic patients are ill because of acid retention, though this man was not acidotic. Acidosis, when present, is caused by retention of acid phosphate. Usually the uremic individual tolerates acidosis quite well, even though it produces the type of dyspnea known as Kussmaul breathing. During the last seven or eight years since the chemistry of potassium has been more closely followed, it has been learned that the uremic individual commonly has elevation of this element in his blood plasma, and that potassium retention may be an important factor.

Actually, however, the picture of uremia is probably caused by a mixture of measurable abnormalities and others that cannot be directly determined. Anemia may be an important side effect, as the uremic state depresses the bone marrow's ability to manufacture blood.

In attempting to come to a conclusion as to the cause of our patient's uremic state, several causes of nitrogen retention may be dismissed without difficulty. The so-called prerenal azotemia associated with pyloric obstruction and vomiting, the nitrogen retention following gastrointestinal hemorrhage, the so-called lower nephron nephrosis that is associated with shock, transfusion reactions, and bichloride poisoning all may be dismissed without discussion. Another very important group of diseases of the kidney that may be associated with uremia and occasionally with hypertension are those in which the lower urinary passages are obstructed, either as high as the kidney pelvis or as low as the urethra. This group may be called the "obstructive uropathies." It is a most important group of diseases because the relief of obstruction may either improve or cure the illness. Ureteral stones, prostatic hypertrophy, ureteral obstruction by carcinoma in the female, must all be considered and proper studies instituted. Cystoscopic examination and retrograde pyelography was not done on our patient, though I doubt very much if any pathology would have been discovered.

I believe that we may narrow our search down to uremia that is characterized by disease of the kidney itself. A number of these can be ruled out without much discussion. Pyelonephritis is a common cause of uremia. It is most important because it is preventable in its early stages. It is characterized, of course, by infection and obstruction of the kidney pelvis and ureters. It is occasionally associated with hypertension. Almost always the microscopic urine examination shows polymorphonuclear leukocytes. It is more common in women than in men. I believe that our patient showed very little to suggest this disease, as the microscopic examination of his urine did not demonstrate pus, and there is nothing to suggest obstruction of urine flow.

Polycystic disease of the kidneys usually becomes evident at the age of fifty or fifty-five. As a rule, the kidneys are quite large and easily palpable.

Diseases of the kidney such as tuberculosis, multiple infarction, and amyloid can cause uremia, but almost invariably the blood pressure is quite low and I believe that they may be eliminated from serious consideration.

I believe that we must narrow our differential diagnostic discussion to the differentiation of glomerular nephritis and malignant hypertension or arteriolar sclerosis. The choice is a very difficult one to make satisfactorily, as at the end of the patient's course, the pictures may be identical.

You will remember that the physical examination described edema of the orbits in spite of vomiting and dehydration. This and the large amount of protein in the urine tempts me to suggest glomerular nephritis. We know that the precipitating streptococcal infection may be forgotten in the patient's past history, and we also know that uremia is more usually the end result of glomerular nephritis than it is of hypertension as such.

Actually, any attempt at differentiation of these two diseases in the terminal state is of purely academic interest. Terminal uremia from either cause cannot be cured. There is also very serious doubt that recognition of the illness several years before would have allowed it to be treated in a reversible state. During the past few years total adrenalectomy has been attempted on patients with malignant essential hypertension, and some are said to be benefited decidedly, even though they accept the inevitable Addison's Disease.

In coming to a definite diagnosis, I must confess to the audience that I discussed this patient once before in a Clinical Pathological Conference for the Senior class of the University of Maryland School of Medicine. At that time I made a diagnosis of chronic glomerular nephritis with uremia. I now know that that was a wrong diagnosis, but in the interest of consistency I must make it again. Dr. Gardner Warner will tell you the proper diagnosis and discuss the picture for you.

Dr. C. Gardner Warner: *Anatomical Diagnosis:* Arteriolar nephrosclerosis, necrotizing; diffuse hyperplastic arteriolar sclerosis; left ventricular hypertrophy; focal myocardial fibrosis; fatty degeneration, myocardium; serifibrinous pericarditis; pulmonary edema.

The body is that of a well developed, well nourished, young colored male. External examination shows little of note. The peritoneal cavity contains no excess free fluid. The liver is somewhat enlarged. The other abdominal viscera are normally disposed. About 200 cc. of serous fluid are seen in each pleural cavity. Old fibrous adhesions are found between the upper lobe of the right lung and the chest wall. The pericardial sac is distended; it contains about 500 cc. of yellowish fluid. The epicardium is dulled by fine strands of fibrin. The heart weighs 600 gm. The wall of the right ventricle measures 5 mm. in thickness and that of the left ventricle 22 mm. in thickness. The valves appear normal. Beneath the mural endocardium yellowish flecks characteristic of fatty degeneration are noted.

The kidneys, right and left, weigh respectively 150 and 200 grams. The capsules are slightly adherent and the cortical surfaces are somewhat granular. Small areas of hemorrhage are seen beneath the capsules and in the cortices of both kidneys. The principal histologic changes in the kidneys are those observed in the arterioles. The walls of the afferent glomerular capillaries are quite thick; they are acidophilic and smudgy in appearance. Similar focal changes are noted in the capillaries of the glomerular tufts. Hemorrhage is seen in some of the subcapsular spaces. Some of the tubules are atrophic and collapsed; others are dilated and contain hyalin and red cell casts. The arterioles in other organs, notably the pancreas, show changes similar to those seen in the kidneys.

This is a case of primary or essential hypertension.

Discussion

Primary or essential hypertension has been so called because there seems to be no proven primary lesion. It has been clinically divided into benign and malignant types on the basis of duration and rapidity of progression. For a long time, it has been recognized that renal arteriolar sclerosis is an almost constant post mortem finding in essential hypertension. The arteriolar sclerosis is often, but not always, a generalized change. It is seen in the spleen, pancreas, adrenals, brain and heart, but it is only in the kidneys that this hyperplastic arteriolar thickening and hypertension seem to have a close correlation. There is still some uncertainty as to whether it be a cause or effect relationship.

The importance of renal vascular changes in hypertension have been pointed out and emphasized by Goldblatt and others, who have demonstrated that ischemic renal tissue releases a pressor substance into the circulation, which by its constrictive action on peripheral vessels, produces hypertension.

Whether the process is benign or malignant, it seems that the pathogenesis is fundamentally the same. The malignant form occurs particularly in young adults, especially the Negro male, as in this case. It is more rapidly progressive and has severer lesions, but follows the same pattern of arteriolar nephrosclerosis and cardiac hypertrophy, with renal, rather than cardiac failure. Pathologically, the malignant variety is characterized by a smudgy hyalin necrosis of small arteries and afferent glomerular arterioles, with small hemorrhages from severely damaged vessels. This necrotizing arteriolitis may produce some inflammatory cellular response. It may extend and involve glomerular capillaries with hyalin thrombosis or capsular hemorrhages. The pathologic findings may be modified somewhat when a benign hypertension has a superimposed malignant terminal phase. In the latter case, varying chronic changes, with hyalinization, glomerular atrophy and tubular collapse are present, in addition to the patchy necrotizing arteriolitis and hemorrhage.

In the case under consideration, such must be the final conclusion. The eight year history of hypertension, a 600 gm. heart, widespread hyperplastic arteriolar changes, granular kidneys with chronic glomerular and tubular changes, make the process one of relatively slow evolution.

The case is therefore one of benign essential hypertension and nephrosclerosis with a terminal malignant phase and death by renal failure.

PLAN TO ATTEND THIS MEETING

Symposium on the Medical and Social Aspects of the Adoption Law of the State of Maryland under Chapter 63 of the Acts of 1950

Osler Hall, 1211 Cathedral Street, Baltimore

Friday, February 6, 1953, 8:00 p.m.

Speakers

1. The Honorable Herman Moser, Judge of the Supreme Court of Baltimore City
2. G. C. A. Anderson, Esquire
3. Georgeanna Seegar Jones, M.D.

A cordial invitation is extended to the members of the Medical and Chirurgical Faculty to attend this Symposium, as the subject is one of interest to the Medical Profession of Maryland.

Component Medical Societies

ANNE ARUNDEL COUNTY MEDICAL SOCIETY

GEORGE C. BASIL, M.D.

Journal Representative

The following were recommended for the County Medical coroner: E. G. Linhardt, M.D.; G. H. Faubert, M.D.; and M. W. Alden, M.D.

Since the last meeting of the Anne Arundel County Medical Society the most important news has been the inauguration of the processes starting the new wing to the Anne Arundel General Hospital.

Ground-breaking ceremonies marking the beginning of construction on the new $1,500,000 Baldwin Memorial Wing of the Anne Arundel General Hospital were witnessed by more than 100 persons on Thursday, November 6, 1952, on the hospital grounds.

The 60 minute program, which got underway shortly before 2:30 P.M., was culminated with the actual breaking of the sod by Summerfield Baldwin, Jr., who three years ago set the wheels in motion to raise a building fund for the new wing by donating $375,000 to the cause.

At the outset of the activities the hospital fund was enriched by $1,500 when Vaughan B. Mantor, a representative of the Farm Bureau Insurance Company, presented a check for that amount on behalf of his firm.

CALVERT COUNTY MEDICAL SOCIETY

PAGE C. JETT, M.D.

Journal Representative

At a meeting of the Calvert County Medical Society on November 11, 1952, the following officers were elected for the new year: *President*, Dr. Hugh W. Ward; *Vice-President*, Dr. George J. Weems; *Secretary-Treasurer*, Dr. Page C. Jett; *Delegate*, Dr. George J. Weems; *Alternate*, Dr. R. de Villarreal.

DORCHESTER COUNTY MEDICAL SOCIETY

WALTER B. JOHNSON, M.D.

Journal Representative

The Dorchester County Medical Society has been holding its monthly meetings in the homes of the various members, following alphabetical order, and a very good attendance has resulted from this arrangement.

The past few months four new members have become affiliated with this society—one by application and three others by transfers from other component societies. They are as follows: Dr. George Parton, Jr., graduate Cornell University, Medical College 1945, General Medicine; Dr. Robert Reddick, graduate of Hahnemann Medical College 1937, Senior Psychiatrist, Eastern Shore State Hospital; Dr. Elizabeth Winiarz, graduate of Poznan Medical College, Poland, Psychiatrist for Mental Hygiene Clinics; and Dr. Witold V. Winiarz, graduate of University of Lwow, Poland, Physician—Eastern Shore State Hospital.

At the meetings in 1952, guest speakers from Baltimore spoke on five occasions, two moving pictures were shown, two strictly business meetings and one summer social function were held. In June and July no meetings were scheduled.

The election of officers for 1953 will be held at the Annual Meeting in December and their names are not yet available for publication. A report of the results of this election will be forwarded in January.

QUEEN ANNE'S COUNTY MEDICAL SOCIETY

C. RODNEY LAYTON, M.D.

Secretary

The Annual Meeting of the Queen Anne's County Medical Association was held November 20, 1952, and the following officers were elected to serve from January 1, 1953 to January 1, 1954: *President*, Dr. Theodor Sattelmaier; *Vice-President*, Dr. C. Rodney Layton; *Secretary-Treasurer*, Dr. Frederick

T. Shepherd; *Censor*, Dr. H. F. McPherson; *Delegate*, Dr. Norman S. Dudley; *Alternate Delegate*, Dr. W. H. Fisher.

WASHINGTON COUNTY MEDICAL SOCIETY

E. F. POOLE, M.D.

Secretary

The Washington County Medical Society held its meeting on October 23, 1952. "Treatment of Anemia" was the address given by Dr. C. Lockard Conley, M.D., Associate Professor of Medicine, The Johns Hopkins University Medical School.

Dr. Newland E. Day presented a talk regarding "Contributions to the American Medical Education Foundation." Dr. Day is the Chairman of this Committee for the Medical and Chirurgical Faculty.

The following officers were elected for 1953: *President*, Ira L. Houghton; *Vice-President*, A. R. Cohen; *Secretary-Treasurer*, E. F. Poole; *Member Board of Censors*, L. H. Brumback.

* * * * *

BALTIMORE CITY MEDICAL SOCIETY

WETHERBEE FORT, M.D., *President* EDWARD F. COTTER, M.D., *Secretary*
1211 Cathedral Street

Friday, February 20, 1953, 8:30 p.m.

SYMPOSIUM ON DIABETES

Participants

General Management. J. Sheldon Eastland, M.D.
Diabetic Neuropathies. Frank R. Ford, M.D. (By invitation.)
Juvenile Diabetes. Harriet G. Guild, M.D. (By invitation.)
Peripheral Vascular Disturbances. George H. Yeager, M.D.
Diabetic Emergencies; Pre and Postoperative Treatment. Benjamin F. Jones, M.D.

Question period

* * * * *

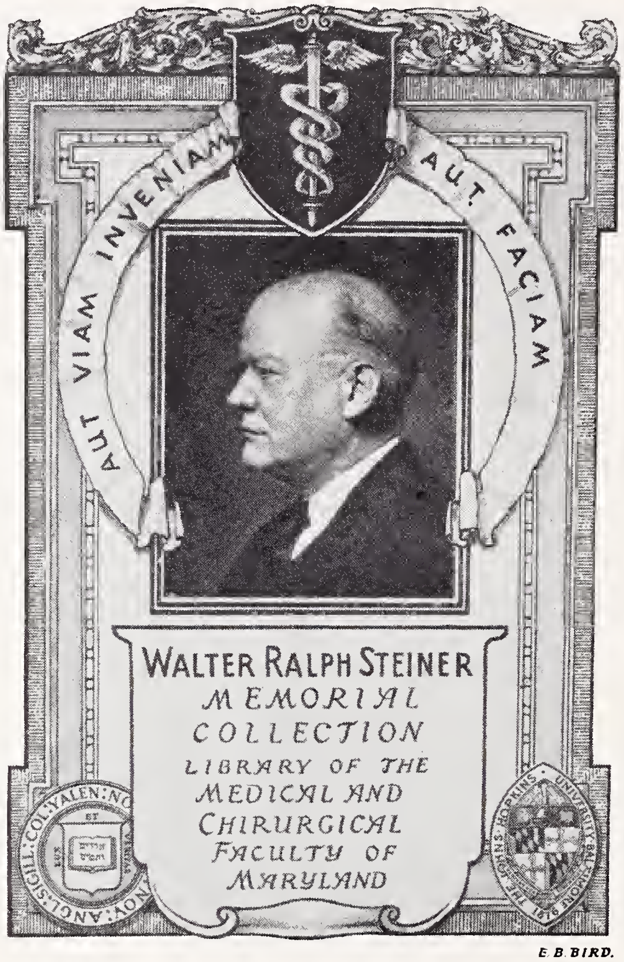
SURGICAL SECTION
BALTIMORE CITY MEDICAL SOCIETY

DANIEL J. PESSAGNO, M.D., *Chairman* E. RODERICK SHIPLEY, M.D., *Secretary*

Thursday, February 19, 1953, 8:30 p.m., Mercy Hospital

An interesting scientific program will be presented by the Surgical Staff of the Mercy Hospital.

Library



THE WALTER RALPH STEINER MEMORIAL COLLECTION

Walter Ralph Steiner was born in Frederick County, Maryland, on November 18, 1870, and died at Hartford, Connecticut, on November 4, 1942. His father, Dr. Lewis Henry Steiner, received his M.D. from the University of Pennsylvania in 1849 and practiced his profession in Frederick until 1861, when he abandoned the strenuous life of a practitioner for the teaching of chemistry and pharmacy. Dr. Lewis Steiner was an active participant in the affairs of medicine, education, politics and sanitation in the State of Maryland. He served as President of the Frederick County School Board and was an active member of the Medical and Chirurgical Faculty, delivering the annual oration in the years of 1856 and 1874. His interest in politics was shown by the twelve years (1871 to 1883) that he spent in the State Senate. During the Civil War, he was the Chief Inspector of the United States Sanitary Commission of the Army of the Potomac. He ended his brilliant career as the first Librarian of the Enoch Pratt Free Library in Baltimore (1884 to 1892).

Thus it was that the career of Lewis Henry Steiner served to exert a lasting influence upon his son. Walter Steiner received his early education from private tutors, the Frederick Academy and the University School of Baltimore. In 1892, he received his B.A. degree from Yale University. The next six years were spent at Johns Hopkins University doing graduate work in chemistry, biology and medicine and receiving his medical degree in 1898. After graduation, he served as a house officer under Osler, Halsted and Kelly; and, concluding this service in 1900, he moved to Hartford, Connecticut, to begin his practice.

Dr. Walter Steiner not only followed his father in his profession but also in his love of books; and because of this, his avocations were centered around the printed page. His non-medical library, containing valuable collections on Nathan Hale, John Paul Jones, Hawaiian literature and prison life during the Civil War, was given where it would serve the most need. His private collection of medical books, which were presented to our library, comprises approximately 3,000 volumes and represents his interest in medicine and medical history for a period of over forty years. This collection, known as the Walter Ralph Steiner Memorial Collection, contains many rare items—a first edition of *Religio Medici*; *The Gold Headed Cane*; Laurentius, Andreas, *Historia Anatomica Humani Corporis et Singularum Ejus Partium Multis Controverisiis et Observationibus Novis Illustrata*; a set of reprints by Dr. Lewis Steiner and many quaint pamphlets, particularly those relating to the Elisha Perkin's Metallic Tractors, which are choice items in our collection of Early American Medicine.

Not only was Dr. Steiner an enthusiastic book collector but he also was one of the eminent writers of his day. His contributions to medical literature fall into two groups: historical and clinical studies. He considered his historical studies the most important of his writings. His first historical paper, *A Contribution to the History of Medicine in the Province of Maryland*, was published in the *Johns Hopkins Hospital Bulletin* in 1902. In each of the historical studies, a wide knowledge of the subject and the period is evident. In his clinical papers, the first of which was published in 1900, he frequently attempts to point out new methods or new diseases of significance to the local physicians. His scientific articles reflect careful observation, knowledge of the literature and mature judgment.

Dr. Steiner found the time to care for a large private practice, to serve as consultant to many hospitals and to serve in an official capacity for many of the medical associations, both local and national. His leadership will be long remembered by the many interns and physicians, who were associated with this prominent man. During World War I, he was Chairman of the Hartford Medical Advisory Board; and, under his brilliant leadership, the Board was very effective and successful.

Following the example of his father, who had been the first Librarian of the Enoch Pratt Free Library in Baltimore, Dr. Steiner devoted himself to the Hartford Medical Society Library, serving as its Librarian from 1903 until 1941. It was during these years that the facilities of the library were so modernized and enlarged that it became known as an outstanding medical society library. When the Society hung his portrait in the reading room and gave his name to the Library, it was universally acclaimed as a fitting memorial to one who had done much for the institution. His eminence as a librarian was further shown by his election to the Presidency of the Medical Library Association in 1931.

As an active participant in the work of historians, he was a member of the Maryland Historical Society, the Virginia Historical Society, the Connecticut Historical Society, the Charaka Club, the American Association of the History of Medicine and the Beaumont Medical Club. To each of these organizations, he contributed noteworthy papers.

He has been described as a quiet, unassuming man, who persuaded by reason rather than by oratory and who was saturated with the love of books; yet a genuine disciple of Hippocrates with true sympathy and understanding for the sufferers who came under his care.

Dr. Walter Ralph Steiner left his medical books to the Medical and Chirurgical Faculty Library; and made the Faculty the residuary legatee of his estate, as a memorial to his father, Dr. Lewis H. Steiner of Frederick and Baltimore. This "trust fund was to be known and designated as the Lewis Henry Steiner Fund, the income from said fund to be used and applied by said corporation in perpetuity for the purchase of medical periodicals and of books and monographs dealing with special branches of medicine or surgery."

All books from the private collection of Dr. Walter Ralph Steiner have a specially designed bookplate.

REFERENCES

Blumer, George, Walter Ralph Steiner, Bull. Hist. Med. **14:** 229–236, 1943

Cordell, E. F., The Medical annals of Maryland, Baltimore, Williams & Wilkins Co., 1903, pp. 579–580

A Noteworthy bequest, Bull. Med. Chir. Fac. Maryland, January 1943, p. 2

Steiner, W. R., Obituaries, Connecticut M. J. **7:** 442–443, 1943

RECENT PUBLICATIONS BY FACULTY MEMBERS

Abeshouse, B. S., and Ruben, M. E., Prostatic and periprostatic phlebography, J. Urol. **68:** 640–646, September 1952

Abeshouse, B. S., and Tankin, L. H., Retrocaval ureter, Am. J. Surg. **84:** 383–393, October 1952

Allan, W. B., The Benefit of respiratory exercises in the emphysematous patient, Am. J. M. Sc. **224:** 320–323, September 1952

Austrian, Robert, Observations on the transformation of pneumococcus in vivo, Bull. Johns Hopkins Hosp. **91:** 189–196, September 1952

Bachs, Agustin, and Walker, A. E., Surgical clinic on hydrocephalus, S. Clin. North America **32:** 1347–1361, October 1952

Bahnson, H. T., Coarctation of the aorta and anomalies of the aortic arch, S. Clin. North America **32:** 1313–1326, October 1952

Baldwin, David, Robinson, P. K., and Lilienthal, J. L., Jr., Interrelations of magnesium, potassium and creatine in skeletal muscles in man, J. Clin. Investigation **31:** 850–858, September 1952

Beacham, E. G., Irregular discharge, Am. Rev. Tuberc. **66:** 213–218, August 1952

Beck, H. G., Obituary, Ann. Int. Med. **91:** 420, August 1952

Berman, E. F., The Plastic esophagus, Sinai Hosp. J. **1:** 40–44, March 1952

Bradley, J. E., and Tilghman, Margaret, In situ hydrogen ion measurements of the mouth, esophagus and stomach in newborn infants, Am. J. Digest. Dis. **19:** 255–257, August 1952

Browne, K. M., Stern, W. E., and Walker, A. E., Cerebral arterial shunt, A. M. A., Arch. Neurol. & Psychiat. **68:** 58–65, July 1952

Broyles, E. N., The Relationship of bronchoscopy to chest surgery, Laryngoscope **62:** 784–786, August 1952

Broyles, E. N., Window laryngofissure operation for small malignant growths of the vocal cord, West. J. Surg. **60:** 387–388, August 1952

Chesney, A. M., The Coming of full time to the Hopkins and Halsted's attitude toward the plan, Surgery **32:** 482–484, September 1952

Conley, C. L., Disorders of the blood in disseminated lupus erythematosus (editorial), Am. J. Med. **13:** 1–2, July 1952

Conley, C. L., and others, Prolonged treatment of pernicious anemia with vitamin B_{12}, Am. J. Med. **13:** 284–293, September 1952

Crowe, S. J., Personal recollections of Dr. Halsted, Surgery **32:** 461–465, September 1952

Cullen, T. S., Plastic bag for urethral leakage control after prostatectomy, J. A. M. A. **149:** 1309, August 2, 1952

Cushing, J. G. N., Problems of retirement, Ment. Hyg. **36:** 449–455, July 1952

Edgerton, M. T., Plastic repair of congenital defects associated with spina bifida and cranium bifidum, S. Clin. North America **32:** 1327–1345, October 1952

Ellis, F. A., Discussion, in Cawley, E. P., Wheeler, C. E., and Wilhite, P. A., Herpes gestationis and the Rh factor, South. M. J. **45:** 832, September 1952

Feldman, Maurice, Morrison, Samuel, and Myers, Philip, The Clinical evaluation of prolapse of the gastric mucosa into the duodenum, Gastroenterology **22:** 80–102, September 1952

Finberg, Laurence, and Chow, B. F., Lack of effect of supplementary vitamin B_{12} administered to premature infants, A. M. A., Am. J. Dis. Child. **18:** 165–167, August 1952

Finberg, Laurence, and Easton, R. S., Generalized cutaneous herpes simplex, J. Pediat. **41:** 188–201, August 1952

Firor, W. M., The Story of the Hunterian Laboratory, Surgery **32:** 485–487, September 1952

Golden, Mano, and Abeshouse, B. S., Prostatic calculi and neoplasm, Sinai Hosp. J. **1:** 20–28, March 1952

Grafflin, A. L., and Bagley, E. H., Glomerular activity in the frog's kidney, Bull. Johns Hopkins Hosp. **91:** 306–317, October 1952

Grafflin, A. L., Gray, N. M., and Bagley, E. H., Studies of α-ketoglutaric acid oxidase activity in washed residues of the mammalian kidney, Bull. Johns Hopkins Hosp. **91:** 137–152, August 1952

Grimble, A. S., and Hahn, R. D., Second infection in treated and untreated congenital syphilis, Am. J. Syph. **36:** 439–444, September 1952

Grob, David, and Harvey, A. M., Effect of adrenocorticotropic hormone (ACTH) and cortisone administration in patients with myasthenia gravis and report of onset of myasthenia gravis during prolonged cortisone administration, Bull. Johns Hopkins Hosp. **91:** 124–136, August 1952

Guild, H. G., Walsh, F. B., and Hoover, R. E., Ocular cystinosis, Am. J. Ophth. **35:** 1214–1248, September 1952

Hartmann, R. C., Conley, C. L., and Poole, E. L., Studies on the initiation of blood coagulation. III. The Clotting properties of canine platelet-free plasma, J. Clin. Investigation **31:** 685–691, July 1952

Hills, R. G., and Firor, W. M., The Use of more potent cobra venom for intractable pain, American Surgeon **18:** 875–879, September 1952

Hoffman, Elmer, The Phrenic rebound phenomenon—a new physical sign, Ann. Surg. **136:** 316–325, August 1952

Hollender, M. H., Psychological reactions to cortisone, Psychosom. Med. **14:** 306–308, July-August 1952

Hornibrook, J. W., The Avidity of test toxins in relationship to tetanus antitoxin titrations, J. Lab. & Clin. Med. **40:** 58–66, July 1952

Jewett, H. J., Diagnosis and management of urinary tract obstructions in children, S. Clin. North America **32:** 1371–1388, October 1952

King, A. B., Chambers, J. W., and Garey, James, Primary malignant melanoma of the spinal cord, A. M. A., Arch. Neurol. & Psychiat. **68:** 266–275, August 1952

Languth, H. W., Teasdall, R. D., and Magladery, J. W., Electrophysiological studies of reflex activity in patients with lesions of the nervous system. III. Motoneurone excitability following afferent nerve volleys in patients with rostrally adjacent spinal cord damage, Bull. Johns Hopkins Hosp. **91:** 257–266, October 1952

Levi, J. E., and Lewison, E. F., Malignant melanoma in a patient with ovarian agenesis. Case report of prolonged survival, J. Clin. Endocrinol. & Metabolism **12:** 901–907, July 1952

McGoon, D. C., Teratomas of the neck, S. Clin. North America **32:** 1389–1395, October 1952

Magladery, J. W., and others, Electrophysiological studies of reflex activity in patients with lesions of the nervous system. I. A Comparison of spinal motoneurone excitability following afferent nerve volleys in normal persons and patients with upper motor neurone lesions, Bull. Johns Hopkins Hosp. **91:** 219–244, October 1952

Marek, C. B., and Dolce, J. R., The Lower midline incision, Maryland State Medical Journal **1:** 447–452, September 1952

Marshall, Curtis, and Harden, Charles, Use of rhythmically varying patterns for photic stimulation, EEG Clin. Neurophysiol. **4:** 283–287, August 1952

Meyers, M. C., Miller, Stanley, Linman, J. W., and Bethell, F. H., The Use of ACTH and cortisone in idiopathic thrombocytopenic purpura and idiopathic acquired hemolytic anemia, Ann. Int. Med. **91:** 352–361, August 1952

Mirsky, I. A., Futterman, Perry, Kaplan, Stanley, and Broh-Kahn, R. H., Blood plasma pepsinogen. I. The Source, properties, and assay of the proteolytic activity of plasma at acid reactions, J. Lab. & Clin. Med. **40:** 17–26, July 1952

Moore, J. E., and Mohr, C. F., Biologically false positive serologic tests for syphilis, J. A. M. A. **150:** 467–473, October 4, 1952

Otenasek, F. J., Brain tumors in childhood, S. Clin. North America **32:** 1363–1370, October 1952

Park, E. A., Address at the banquet given in honor of Dr. Harry H. Gordon, new pediatrician in chief, and Dr. Alexander J. Schaffer, retiring pediatrician, Sinai Hosp. J. **1:** 7–13, March 1952

Park, E. A., John Howland Award Address, Pediatrics, **10:** 82–108, July 1952

Park, E. A., A Pediatrician's chance recollections of Dr. Halsted, Surgery **32:** 472–478, September 1952

Patz, Arnall, Hoeck, L. E., and Cruz, E. D. L., Studies on the effect of high oxygen administration in retrolental fibroplasia, Am. J. Ophth. **35:** 1248–1253, September 1952

Peirce, E. C., The Use of viably preserved tissue for homologous arterial grafts, Ann. Surg. **136:** 228–238, August 1952

Pincoffs, M. C., The American College of Physicians and the internist of the future, Ann. Int. Med. **37:** 253–260, August 1952

Proctor, D. F., Studies of respiratory air flow in measurement of ventilatory function, Dis. Chest **22:** 432–446, October 1952

Ravitch, M. M., Consideration of errors in the diagnosis of intussusception, A. M. A., Am. J. Dis. Child. **84:** 17–26, July 1952

Ravitch, M. M., Bahnson, H. T., and Johns, T. N. P., Carcinoma of the esophagus, J. Thoracic Surg. **24:** 256–270, September 1952

Ravitch, M. M., and Handelsman, J. C., Lesions of the thoracic parietes in infants and children: deformities and tumors of the chest wall, abnormalities of diaphragm, S. Clin. North America **32:** 1397–1424, October 1952

Reinhoff, W. F., The Impact of Halsted upon surgical technique of today with particular reference to his operation for hernia, Surgery **32:** 493–497, September 1952

Rich, A. R., The Occurrence of focal tuberculoid lesions in experimental serum sickness, Bull. Johns Hopkins Hosp. **91:** 109–123, August 1952

Robinson, H. M., Sr., Artane in the treatment of morphea and scleroderma, a preliminary report, J. Invest. Dermat. **19:** 171–173, September 1952

Robinson, H. M., Jr., and others, Leukopenia, a complication of chloromycetin therapy of chronic discoid lupus erythematosus, J. Invest. Dermat. **19:** 199–204, September 1952

Roman, P. W., Wagner, J. H., and Steinbach, S. H., Massive fatal embolism during barium enema study, Radiology **59:** 190–192, August 1952

Rosen, Harold, The Hypnotic and hypnotherapeutic unmasking intensification, and recognition of an emotion, Am. J. Psychiat. **109:** 120–127, August 1952

Sabiston, D. C., Jr., and Blalock, Alfred, The Surgical treatment of congenital heart disease accompanied by cyanosis, S. Clin. North America **32:** 1273–1297, October 1952

Sachs, Louis, Description of a compound tube for the simplification of common duct drainage, Sinai Hosp. J. **1:** 29–39, March 1952

Sacks, M. S., The Present status of therapy in acute leukemia (editorial), Ann. Int. Med. **91:** 400–403, August 1952

Schoenbach, E. B., Miller, J. M., and Long, P. H., The Treatment of systemic blastomycosis with stilbamidine, Ann. Int. Med. **37:** 31–47, July 1952

Schuman, William, A Reduced external conjugate (baundelocque) diameter as an index of contracted pelvis, Sinai Hosp. J. **1:** 45–52, March 1952

Scott, H. W., Jr., Surgical treatment of patent ductus arteriosus in childhood, S. Clin. North America **32:** 1299–1312, October 1952

Shipley, A. M., Personal glimpses of Dr. Halsted, Surgery **32:** 469–471, September 1952

Steinberg, Murray, A Study of the operation of radical abdominal panhysterectomy with bilateral pelvic lymph node dissection at the Sinai Hospital of Baltimore from 1949–1951, Sinai Hosp. J. **1:** 53–60, March 1952

Teasdall, R. D., Languth, H. W., and Magladery, J. W., Electrophysiological studies of reflex activity in patients with lesions of the nervous system. IV. A Note on the tendon jerk, Bull. Johns Hopkins Hosp. **91:** 267–275, October 1952

Teasdall, R. D., Park, A. M., Languth, H. W., and Magladery, J. W., Electrophysiological studies of reflex activity in patients with lesions of the nervous system. II. Disclosure of normally suppressed monosynaptic reflex discharge of spinal motoneurones by lesions of lower brain-stem and spinal cord, Bull. Johns Hopkins Hosp. **91:** 245–256, October 1952

Thomas, C. B., What is the mode of action of thiocyanate compounds in essential hypertension? Ann. Int. Med. **37:** 106–122, July 1952

Walker, A. E., Head injuries, Mod. Med. **20:** 91–99, September 1, 1952

Walker, A. E., Introductory remarks. Symposium, photometrazol activation of the electroencephalogram, EEG Clin. Neurophysiol. **4:** 263–264, August 1952

Walsh, F. B., Myasthenia gravis—diagnosis and treatment, Rocky Mountain M. J. **49:** 757–766, September 1952

Whitehorn, J. C., The Meaning of medical education in our society, Am. J. Psychiat. **109:** 81–88, August 1952

MARK THESE DATES ON YOUR CALENDAR!

Annual Meeting—TUESDAY and WEDNESDAY, APRIL 28 and 29, 1953

The Committee on Scientific Work and Arrangements has almost completed plans for the 1953 Annual Meeting of the Medical and Chirurgical Faculty. The I. Ridgeway Trimble Fund Lecture will be given by Dr. J. S. L. Browne, Chairman of the Department of Medicine, McGill University, Montreal. The J. M. T. Finney Fund Address will be by Dr. Robert R. Linton of Brookline, Massachusetts.

The first Harvey Grant Beck Memorial Fund Lecture will be one of the features of the program this year. Mrs. Beck has presented this memorial in memory to her husband, Dr. Harvey Grant Beck, who died in October 1951.

The business meetings will commence on Monday, April 27, 1953 and will also be held on Tuesday and Wednesday, April 28 and 29, 1953.

Health Departments

MARYLAND STATE DEPARTMENT OF HEALTH

The Nursing and Convalescent Home in the Community's Total Medical Care Program*

CLETUS L. KRAG, *Senior Assistant Surgeon*†

[*The nursing and convalescent homes have become such an important part of the total Medical Care Program that the State Department of Health feels it is important that material which would assist the medical profession into a proper understanding of such institutions is important.*]

The nursing and convalescent home can be thought of as playing at least four closely related and overlapping roles in the community's total medical care program: First, it may serve primarily as a shelter furnishing simple care for those with chronic or prolonged illnesses. Second, it may serve as a hospital substitute providing low cost care. Third, it may serve as a retreat wherein is offered custodial or general care of the infirm and senile aged. And fourth, as a "last resort" home for people whom no one else will care for. Let's examine some of the implications involved in each of these situations.

The first role just mentioned is that of serving primarily as a shelter furnishing simple care for those people with chronic or prolonged illness. There are several questions that arise immediately about this statement. One is, what is shelter? Another one, what is simple care? A third question also arises, and that is, what are chronic and long-term illnesses?

First of all, shelter implies protection—against the weather, for example. In connection with the care of older people, it implies protection from the vicissitudes of the environment, freedom from the struggles of day to day living. Thus, it involves more than merely providing food, clothing, a roof and four walls, and a bed to sleep in. It is more than just a hotel, a house, or a building in which food is served, beds are made, and floors and walls are kept clean. The missing ingredient is personal services—that is, care of the person who is sheltered. Thus, there is more involved than the problems concerning the type of building, its location, how it is operated, how clean the floors and linens are, and so forth. The type and quality of personal services is what distinguishes the nursing and convalescent home from a hotel, a resort, a rooming house, or an apartment house.

This brings us to the question of what is "simple care." When we speak of the care of people in nursing homes, we think of people who require nursing services, and, obviously, the reason these people need this type of care is because they are sick. The point must be emphasized that nursing homes take care of sick people, just as hospitals take care of sick people. However, while their functions do overlap in this way, nursing homes and hospitals are not the same. And one of the keys to an interpretation of the role of nursing and convalescent homes in the total medical care facilities of a community can be found in this overlap of function.

It is often stated that both the hospital and the nursing home are capable of and frequently do render "simple care." It is also stated that the nursing home sells "nursing service." There is a need for a better understanding of the meaning of these terms. For example, just how simple should "nursing care" be? There may not be an explicit answer to this, but it is worthwhile to consider some of the ingredients required in rendering this care.

One of the limiting factors regarding the type or level of care possible in a given nursing and convalescent home is the equipment available. Obviously, bed care cannot be given without the proper equipment for bed services. Likewise, meals in bed require special equipment such as trays and drinking straws. But actually, this is relatively simple and easy to achieve. At times, however, nourishment must be given through tubes; sometimes into the stomach and sometimes into a vein. Fluids may often be given under the skin. Although the equipment used in these procedures is fairly simple, it is, nevertheless, special.

---

* Presented at annual meeting of Indiana Association of Licensed Nursing Homes on June 16, 1952 in Indianapolis, Indiana.

Reprinted by courtesy of "Public Welfare In Indiana," July 1952 issue.

† Officer in Charge, Hygiene of Aging, Division of Chronic Disease and Tuberculosis, U. S. Public Health Service.

And feeding is not the only problem. Patients may have diabetes, or pernicious anemia, or acute infections—all of which may require hypodermic medications given by special equipment. Furthermore, some patients need wheelchairs, crutches, and fracture beds.

Equipment, then, is one of the important limiting factors regarding the level of care given in a nursing home, and the type and amount of equipment may be limited only by the expense involved in buying and maintaining the equipment and by the complexity of its operation.

Closely related to the matter of equipment is the matter of the capabilities of the staff. The concept of "simple care" is actually a relative one, depending largely on the capabilities of the person rendering the care. We all know that training and experience will alter a person's conception of what is simple and what is not. A person with limited training can adequately supply a few pills, empty a bed pan, and bathe a patient in bed. This is an obviously simple kind of care. To a person with more training, however, more complicated matters may still be considered simple—changing surgical dressings, for instance, giving hypodermic injections, testing urine for sugar, preparing a meal for the diabetic patient, or administering oxygen. If this trained person is a nurse with good knowledge and experience, she can also recognize early symptoms of a change in the patient's condition, obtain blood samples by venipuncture, pass catheters, and carry out many other procedures. To a still more highly trained person such as a physician, more complicated matters constitute "simple care," and may be rendered without much in the way of expensive and complicated equipment.

Thus, we see that entirely different concepts of care can be held by an untrained attendant on the one hand, and by a trained person—such as a nurse or a doctor—on the other. And since not only the *interpretation* of the term "care" but also the *quality* of the care given is dependent upon the training of the person who is caring for the patient, the adequacy of the treatment (no matter how simple or complex) rests on the calibre of the equipment and staff offered by the nursing home.

This is not to disparage or discount simple care in the narrow sense. The modern nursing home *must* provide for the basic needs of food and shelter. But it should also be in a position to carry out certain easily managed procedures. It is clear, then, that the ability of a nursing home to carry out these procedures depends not so much on beds, chairs, dishes, and trays—equipment, in other words—as it does upon the training and abilities of the staff.

It will be recalled that the first role we listed for the nursing home was that of caring for those sick people who require a simple or limited type of care, usually for an illness that is prolonged. Let us now try to define what is meant by a prolonged or long-term illness. In general, this implies a type of illness that is either thought to be incurable or one in which a rapid cure is not expected. Too often in the past this has been synonymous with neglect, and referred to as an illness requiring "custodial" care only. This concept, however, is rapidly changing as newer drugs are discovered, the potentialities of adequate nutrition are appreciated, and advances in rehabilitation are applied. More than ever, chronic or long-term illness is being conquered by the weapons wielded by a well-trained staff.

We know that diseases of the blood vessels affecting the heart, brain, and kidneys are the greatest killers. Cancer is our second greatest killer. Diseases of the joints and bones and of the endocrine glands are also extremely common. Thus, among the patients seen in nursing and convalescent homes, we find people with such conditions as paralysis, mental and physical deterioration, crippling arthritis, diabetes, cancer of various kinds, asthma, heart disease, and tuberculosis.

New discoveries in diagnosis, prevention, and treatment of chronic diseases, however, are making it possible for us to care for these people much better than we could 5, 10, or 20 years ago. For example, early treatment of the patient with a cerebrovascular accident makes it possible to prevent serious crippling and helplessness. Chronic heart failure can be improved, dramatically at times, by proper diet and drugs. Pneumonia, which formerly killed so many of our older people—particularly if already disabled—is easily treated by such drugs as penicillin.

Diabetes, by the way, is a rather good example of a chronic disease about which nursing and convalescent homes should be more concerned. Perhaps one person out of every 15, over the age of 65, has diabetes; and as our older population increases, so does the number of diabetics. Since the advent of insulin, this is a disease which can be easily cared for by a trained staff—but it is difficult and dangerous for the untrained to care for diabetic patients. We must not forget, however, that it is relatively easy for a registered nurse to obtain the necessary training if she does not already have it. Furthermore, the proper care of a diabetic patient requires little more, in the way of physical equipment, than a few test tubes, chemicals, needles, syringes, and diet prescriptions. The proper use of this equipment, however, requires training and experience if the diabetic patient is to receive adequate care.

Diabetes is also a disease that is not usually diagnosed at an early stage. Too often it is not discovered until long after serious complications have arisen, such as gangrene of the feet, cerebrovascular accident, heart attack, or blindness. This means that those who care for old people must be on the alert for this disease, and should be familiar with its course and its treatment.

To be sure, medical discoveries and advances are important in terms of saving lives. However, we must not overlook another important part of the picture: the alleviation of the pain, discomfort, and mental depression of those with incurable and progressive diseases who are nearing the end of their lives. Many of us have seen the patient with advanced cancer who develops heart failure, pneumonia, or a kidney infection. Obviously, treatment of the complicating or secondary illness contributes little or nothing toward alleviation of the primary disease, but it *can* contribute to the comfort and well-being of the patient as an individual.

Another matter of utmost importance to nursing homes, as we all know, is the patient's nutritional requirements. The effect of diet on the treatment of chronic and long-term diseases has been shown to be most important for diabetes, heart disease, and the healing of infections—to name but a few. Furthermore, it has been shown that the digestive processes of older people slow down and become less efficient. Many old people, particularly those who are sick, are often starved for protein and vitamins. In order to feed these people adequately, it not only takes skill to cook and serve the food properly, but it also takes knowledge about the various foods and the needs of the individual patient. Some nursing homes have been known to serve a daily supper consisting of a dish of stewed tomatoes and a slice of bread. This is a meal obviously lacking in variety and quality. On the other hand, filet mignon (although it is more appetizing and nutritious) is impractical. A thick soup, fruit or vegetable juice, and milk puddings, however, are not only practical and nutritious, but they are also inexpensive. For a person with the proper training, it is not too difficult to plan a variety of low-cost meals that satisfy the eye as well as the nutritional needs of the patient.

The role, then, of the nursing and convalescent home of caring for the chronically ill patient has much in common with that played by a hospital. But it will vary, depending upon the equipment and the experience of the home's staff. Many homes carry out a very fine program in meeting the needs of their patients. They offer care of a kind that is midway between that provided in a general hospital and that which they would receive in their own homes during recovery from long-term illnesses. These nursing homes can often do a better job than the hospital. A more pleasant home-like atmosphere may prevail, and the staff, free from problems related to the needs of the acutely ill and the rapid turn-over of the patients seen so frequently in a general hospital, may devote more attention to individual patients' needs.

And now, let us turn to the second role played by the nursing and convalescent home in the community's program of medical care: the provision of low cost care. In this role, the nursing home may serve as a substitute for either hospitalization or full-time nursing care in the patient's own home—both of which are relatively high in cost. Certainly, the family's motivation underlying the choice of a nursing home, in many instances, is a desire to save money rather than to seek out adequate and complete medical care.

When the nursing home does serve in this capacity, however, it is most important that some degree of medical supervision be maintained over its patients, as well as over its new admissions. Otherwise (and this does happen in some places) seriously ill people will live and die in these homes without ever having received adequate and proper treatment of diseases that are amenable to modern care.

Actually, there is one group which, perhaps, makes up the majority of patients in many nursing and convalescent homes—the infirm and senile aged who are admitted to the home for general care. While on the face of it, it would seem that these people need only food and shelter, there is an obvious danger in thinking of this group only in these terms. This limited type of care is important, to be sure; but we must not overlook the fact that even among those of far advanced age, the care and treatment of their diseases are important from the point of view of providing comfort and alleviation of suffering in their last days.

The last role to be considered has been a real headache for many nursing home operators. It includes the problem of caring for those patients whom no one else will care for. Many of us have been faced with the difficulties that result from dealing with the old, noisy, confused, incontinent individual who has been discharged from a hospital, refused admission to a hospital on the basis of not really needing general hospital care, or who has been transferred from one nursing home to another. The patient, may, perhaps, be an individual whose family was either unable or unwilling to care for in their own home. In serving as a place for those whom no one else will care for, nursing homes have certainly responded to a most vital and pressing community need that at times has been overlooked by those who suggest further regulation of these institutions. We should remember, however, that many of the older people who can be found in nursing homes may be suffering from diseases that can be treated successfully. For example, the delirious and incontinent old man may quite possibly have an obstructing prostate gland complicated by uremic delirium. This condition can be treated, particularly if not too far advanced; and the proper treatment can result in a remarkable improvement in the patient's mental state. With newer developments in knowledge concerning older people and their diseases, we now have an opportunity to give the kind of service which can make nursing homes an even more valuable community asset.

Nursing and convalescent homes, then, play a variety of roles in a community's total medical care program. First, and most important, they serve as a place where those who have a chronic or prolonged illness may receive a limited type of care. Second, they serve as hospital substitutes, providing low cost care. Third, they serve as shelters for the infirm and senile aged. And, finally, they serve as homes for people whom no one else will care for. The types of services offered by these homes cover a wide range, as do the kinds of accommodations. But even with the differences in the ways various homes choose to care for their patients, we can find important, basic requirements in common. Most important is well-trained, qualified and adequate medical supervision. For it is only with experienced people to serve as a nucleus that the modern nursing home can meet the needs of its patients. The essentials of materials; diet; techniques of prevention, diagnosis, and treatment—all can be implemented to a most satisfactory degree in a properly equipped and staffed nursing home.

The facts stated earlier concerning the various chronic diseases are beginning to be recognized by nursing home operators, but they need to be more generally appreciated in the community. Chronic disease requires treatment—good treatment—whether it be heart disease, diabetes, cancer, or paralysis. During the last few years, there have been many new advances in knowledge concerning diet and in the treatment of some of these diseases. How well we put this knowledge to work—and, consequently, how great a role can be played by the nursing home—will depend on how much understanding and support can be found in the community.

One very real way in which this support can be achieved is through State-wide meetings of administrators of nursing and convalescent homes. Participation and planning with local community organizations such as the medical society, hospital associations, and councils of social and welfare agencies is another way of achieving this support. Such participation is indispensable to a thorough understanding by the community of the problems and services of local nursing and convalescent homes. This, however, cannot be achieved without an active local organization of home operators. Still another way in which this support can be obtained is through programs designed to increase the knowledge of operators of these homes. In each community there are a number of people who are highly skilled in working out the problems of nursing home operation. Local medical societies, health departments, councils of social and welfare agencies, and hospital administrators—to name but a few sources—provide assistance in planning and putting on these educational programs.

The nursing and convalescent home of today is a real and integral part of a community's total medical care program. It has met an important need of the public in the past, and we look toward the future when it will make an even greater and more meaningful contribution to society.

R H. Riley

Director

PIANO WANTED

The Woman's Auxiliary to the Baltimore City Medical Society would appreciate the gift of a piano for the Medical and Chirurgical Faculty Building. The Council has approved this request.

RED CROSS ASSUMES COST OF PRODUCING GAMMA GLOBULIN: DISTRIBUTION UNDECIDED

Capitol Clinic, A.M.A., Vol. 3, No. 49, December 9, 1952

American Red Cross has announced that it will assume costs of producing gamma globulin, an action which will result in several changes in the National Blood Program. Because gamma globulin and serum albumin can be processed from the same whole blood, Defense Department and Federal Civil Defense Administration will begin storing serum albumin; both had been storing blood plasma until the Red Cross announcement. While Red Cross *will assume cost of producing* gamma globulin for the nation, it *will not undertake its distribution and allocation*. How this gamma globulin is to be distributed—there will be no charge for it—still has to be decided. State and Territorial Health Officers, meeting here this week, are expected to work out some system for distribution, and make their recommendations to the Office of Defense Mobilization.

Another problem is that of matching supply with demand. Because gamma globulin is considered effective in prevention of paralysis due to poliomyelitis, the public demand for it is expected to far outreach supply by early next summer. Although increased blood donations are expected as a result of the publicity on the new Red Cross campaign, there is little or no possibility of producing, in the immediate future, all the gamma globulin that will be desired.

STATE OF MARYLAND DEPARTMENT OF HEALTH

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, November 28–December 25, 1952

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCAL	MUMPS	POLIOMYELITIS, PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																		
Local areas																		
Baltimore County	42	—	—	1	2	—	1	—	—	13	—	—	5	15	—	7	t-1	5
Anne Arundel	23	—	—	—	—	—	1	—	—	13	—	—	1	10	5	4	—	4
Howard	—	—	—	—	—	—	—	—	—	1	—	—	—	1	—	2	—	—
Harford	8	—	4	—	17	—	—	—	—	—	—	—	—	2	—	3	m-2	—
Carroll	—	—	—	—	2	—	—	—	—	—	—	—	—	1	—	—	—	1
Frederick	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	5	—	—
Washington	8	6	—	2	1	—	—	—	—	2	—	—	—	5	—	—	—	1
Allegany	3	—	—	1	1	—	—	—	—	2	1	—	—	—	1	1	—	1
Garrett	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Montgomery	19	—	—	1	1	—	10	2	—	—	—	—	1	4	—	—	—	2
Pr. George's	33	—	—	1	—	—	12	—	—	3	—	—	—	8	—	9	—	3
Calvert	2	—	—	3	—	—	—	—	—	—	—	—	—	2	—	—	—	—
Charles	3	—	—	—	—	—	2	—	—	—	—	—	—	1	—	1	—	1
Saint Mary's	—	—	—	3	—	—	—	—	—	—	—	—	—	1	1	2	—	—
Cecil	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	3	—	—
Kent	—	—	—	—	1	—	—	—	—	4	—	—	—	2	—	—	—	—
Queen Anne's	—	—	—	—	—	—	—	—	—	1	1	—	—	—	—	—	—	1
Caroline	—	—	—	—	—	—	1	—	—	2	—	—	3	2	—	2	—	—
Talbot	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	1	—	1
Dorchester	1	—	—	—	—	—	1	—	—	—	—	—	—	2	—	—	—	1
Wicomico	16	—	—	—	—	1	—	—	—	1	—	—	—	4	—	16	—	1
Worcester	4	—	—	—	—	—	—	—	—	—	—	—	—	5	—	1	—	—
Somerset	1	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—
Total Counties	163	6	4	12	25	1	28	3	0	42	2	0	10	70	7	57	—	22
Baltimore City	134	2	1	23	17	0	40	1	0	41	1	0	21	93	9	564	—	28
State																		
Nov. 28–Dec. 25, 1952	297	8	5	35	42	1	68	4	0	83	3	0	31	163	16	621	—	50
Same period 1951	224	2	9	23	1009	5	69	5	0	94	2	3	28	142	14	520	—	93
5-year median	266	15	7	—	66	9	95	4	0	90	4	2	170	182	92	520	—	59
Cumulative totals																		
State																		
Year 1952 to date	3278	25	854	264	9171	81	1082	196	29	1050	24	15	226	2637	194	7567	—	638
Same period 1951	3113	39	873	253	7343	57	3746	84	43	948	23	38	455	2648	317	7442	—	577
5-year median	3508	188	400	—	3035	117	1398	155	56	1091	39	41	1419	2717	1271	7602	—	667

m = malaria contracted outside the U. S. A. reported by Aberdeen Proving Grounds, residence not stated.
t = tetanus.

BLUE CROSS AND BLUE SHIELD

BLUE CROSS AND THE NATION

R. H. DABNEY*

We're Proud of Our Symbol.

What is Blue Cross outside the state of Maryland? Is it one big organization, the same all over the country? Who or what is its governing body?

Only those Plans which conform to the standards of organization and operation set up by the Blue Cross Commission of the American Hospital Association may use the symbol of Blue Cross. In reality, the A. H. A. says the symbol and prestige of Blue Cross are yours if you conform to these standards. Among these standards is the one requiring Plans to be non-profit. The Plan must offer equal protection to dependents and ease of admittance to hospitals. It must provide service benefits.

Another requirement to be met is representation on the Board of Directors of hospitals, doctors, and the general public. It is necessary that Blue Cross plans be financially stable.

It is the responsibility of the Blue Cross Commission to see that these standards are met and followed. This Commission is composed of a representative from each of twelve districts and three representatives from the American Hospital Association. The government and organization of the 90 local Plans is handled by the Commission with the assistance of a national director and his staff hired by the Commission. From the Commission headquarters in Chicago, the director and his staff offer assistance to and help coordinate the efforts of the individual Plans.

This organization of 90 different Plans makes it possible for local communities to receive the type of service suited to its needs. At the same time, it assures that certain basic services, needed by all, are provided.

The feature of reciprocity of enrollment which makes any Blue Cross subscriber eligible to transfer to any other Plan without waiting periods or penalities is of great importance to subscribers. Reciprocity of service benefits makes it possible for a Blue Cross subscriber of one Plan while ill and away from home to receive all of the service benefits that are offered by the Plan in the area in which he may be hospitalized.

Last year more than three-quarters of all subscribers provided care away from home were cared for through reciprocity. It is a little realized fact that the service requires a clearing house function in the Inter-Plan Bank which compares with the clearing house mechanism of regular banks.

It is important to point out that by the foregoing, the local Plan loses none of its autonomy. Indeed, each local Plan gains in its ability to serve its community by linking itself in this respect with all of the other plans in the nation.

The national growth of Blue Cross in the years since its inception is a significant tribute to its soundness. Our goal, now as always, is to bring complete health protection within the range of every pocketbook of every person in the country.

Blue Cross has come to be a symbol of integrity and honesty . . . a symbol that means the best protection for millions of people.

---

* Executive Director, Maryland Hospital Service, Inc. and Maryland Medical Service, Inc.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. GEORGE H. YEAGER, *Auxiliary Editor*

CONFERENCE HIGHLIGHTS

MRS. JOHN G. BALL, *President-Elect*

The theme of the November 1952 Conference of our National Auxiliary was "Our Goal—A Better World." It started off on the happy note that President Eisenhower's victory was a victory of conservative thinking and for a stable, friendly, climate for medicine. This is not the time to relax, though, since "*compromise*" bills, proposing that the Federal Government and Private Medicine cooperate on certain programs will no doubt appear. We were warned to watch out for such bills which are just as dangerous in the long run as total compulsory health insurance. However while we keep an eagle eye on legislation we will feel better with a government in Washington that believes in the American system and a President who "didn't know he was poor till he grew up."

In going ahead with a positive program during the next four years to inform the public on the "long range aims" of Medicine you may like to use some new material. A film called "Your Doctor" showing the positive work of medicine will be available after January 1st from Woman's Auxiliary to A. M. A. 535 N. Dearborn Street, Chicago 10, Illinois. It is a 16 mm. picture. Useful reprints available from the same address for distribution at fairs and meetings are a Reader's Digest article, "Your Money's Worth In Health," on Medical care, "The Amazing Story of the A. M. A." and the "A. M. A. Story to Physicians."

We are now on the offensive and can talk of ends, not just means, and the good things that we want for everybody. In this positive approach while the followers of the "isms" argue vague theories we must *live* our beliefs. Books such as "Remember These Things," by Paul Harvey, published by The Heritage Foundation, can help us practice what we preach! Speaking of practice let us respect the nurse as an equal helper on the health team, and do not forget the *practical* nurse towards whom the socializers are now directing their efforts.

Little things that help the Auxiliary to establish an atmosphere of friendliness and unity which are again reflected in the Medical Society, are a permanent Auxiliary Room in the Medical Building, the interest of established members in new members, Doctor's Day programs, and quiz or panel programs.

The Conferences' main new point was the study of the "battle for the minds, hearts and souls of our children" through socialized school books and pamphlets which even give third grade *arithmetic* problems in numbers of "hospital-beds" and the "burdens" of illness. For although we have voted in a new administration, the old teachers, books, and socializers are still "in." An ideological fight exists in the world today! The defection of the self-styled "intellectuals" from our newer American idea of the free individual back to the antique concept of man as the slave of a master government has shocked sensible citizens. We know that the Communists and their dupes are after the minds of our children and can laugh when we defeat them on current legislation, if they still are able to *warp the minds* of our youth and thus control the future!

To establish a *positive* program of teaching American opportunities and the challenges of freedom, know first the problems of the Communists! Read the "Communist Manifesto," 15¢, 510 Dearborn Street, Chicago 10, Illinois, "We Are the Government" a book for the sixth, seventh and eighth grades by Mary Elting, and "Social Disorganization" which is used in the District of Columbia. Other helps, but more on the American side are "Molders of the American Mind," "God and Man at Yale" by Buckley, "God and Woman at Vassar" by Fellman (Freeman Magazine, always good, $5.00 a year, 240 Madison Avenue, New York City 16, N. Y.), "The Educational Reviewer," for direct quotations out of current school texts, quarterly $2.00, 112 E. 36th. St., New York City 16, N. Y.

The Conference covered some bizarre subjects. One such was a battle within the American Legion by persons wishing Chiropractors to practice medicine in Veterans hospitals. Another was the idea of presenting our speakers and officers with huge "phony," paper, orchids so that the money could be sent to the American Medical Education Foundation instead of being spent for flowers. Mention was made of the fact that *private duty* nurses should be released to attend their Nursing Association meetings, which Public Health nurses are given time and pay to attend, and thus, though a small percentage of the profession, are able to *control*. All of the ideas were interesting, and though not all can be used by every Auxiliary, how we wished that every member could have been there for the fun and stimulation.

AUXILIARY NEWS

MRS. EDWIN H. STEWART, JR., *Chairman*

When the Women's Auxiliary to the Baltimore City Medical Society asked us to do something for Nurse Recruitment, my committee met one hot summer evening to consider the most effective way of reaching the greatest number of high school girls with a message about nursing. We very boldly suggested to our Auxiliary that we thought it would be a good idea to produce a new film on our local Hospitals and Nursing Schools. The idea was accepted by our Board, and we immediately began to ask each other "who knows how to make a movie?" My committee members, Mrs. Edward F. Cotter, Mrs. Henry D. Holljes, Mrs. John M. Dennis and I were not quite certain how to go about the endeavor, but Mrs. George H. Yeager, our Public Relations Chairman, came to our rescue. Mrs. Yeager had some very constructive ideas to offer and knew just who to contact for advice and assistance.

A meeting was called on September 19, to which we had invited the Hospital Directors and Directors of Nursing from the Baltimore Hospital Schools of Nursing to ask if they would approve the plan. The meeting was very well attended and a most enthusiastic response was given. Everyone felt that much use would be made of such a local nurse recruitment film!

An Executive Committee was formed from the representatives at the first meeting, to investigate the possible cost and content of the film.

Dr. D. C. Smith, Secretary of the Maryland Society for Medical Research, and Dr. R. Walter Graham, of the Baltimore City Medical Society, have been immeasurably helpful in drawing up the initial plans. Dr. Amos R. Koontz, Dr. George H. Yeager, Dr. Whitmer B. Firor, Dr. Newland E. Day, Chairman of our Advisory Committee, and Dr. George G. Finney have all given us their valuable opinions on various questions that have arisen.

In order to bring some definite findings back to the hospital representatives the Executive Committee appointed a Finance Committee and a Script Committee. Dr. D. C. Smith is Chairman of the Script Committee and Mr. Carroll D. Hill, Director of Union Memorial Hospital, who has been very helpful from the beginning, is Chairman of Finance. We are also most fortunate in having on these committees Hospital and Nursing School Directors. The Script Committee has already submitted an excellent preliminary script and the Finance Committee has collected enough money from the participating hospitals, Maryland Society for Medical Research etc., to begin the actual photography.

A representative of the Nursing Association's "Careers In Nursing Committee," Miss Margaret E. Courtney, is collaborating with us. Our President, Mrs. Albert E. Goldstein, has been most cooperative and frequently lends a helping hand.

It is our hope that when completed, this state-wide film will be interesting enough to encourage young girls of good character from our own and neighboring States to choose nursing as a career. I think it can already be said that its development will be a wonderful example of the American way of doing things, by individual initiative, and with the cooperation of several organizations, to attain some worthwhile objective.

A second project of our Auxiliary Nursing Committee has been directed toward the *graduate* nurse, who has small children. A separate program carried out by Mrs. Henry W. D. Holljes, Co-Chairman, has appealed to the Hospital Auxiliaries to consider operating day nurseries for the pre-school children of Registered Nurses so that their mothers may work at least part time in the hospital. A booklet of Health Department rules and the "Journal" article on the Washington County Hospital Nursing School were *mailed with our suggestions to each Hospital Auxiliary President.* We hope that some Hospital

Auxiliaries in this way, will be in a position to help their Hospital get more graduate nurses back on duty.

NURSE RECRUITMENT—20TH CENTURY METHOD

At a State Board Meeting held on November 14th at the home of our President, Mrs. Charles H. Williams, we learned that Maryland proposed two resolutions at the November Conference in Chicago. The first, proposed by Mrs. Williams, was to amend the National Auxiliary By-Laws so that the President of the Woman's Auxiliary to the American Medical Association can in the future designate her own Conference or Convention Secretary. The second resolution was the idea of our Maryland President-Elect, Mrs. John G. Ball, and was to the effect that the State Presidents-Elect, at future National Conferences and Conventions would sit together at meetings in order to exchange ideas.

The "Bulletin" of the Maryland Society for Medical Research recently carried an article about how Baltimore City Auxiliary members working with Mrs. R. Walter Graham, as Chairman, staffed a Medical Research Booth at the State Teachers Convention. Another article in "The Bulletin" gave a very nice write-up of the Baltimore County, City and State Auxiliary work at the Timonium Fair.

State and City Auxiliary officers are meeting with Civil Defense authorities to plan our Civil Defense contribution.

The Committee on Geriatrics of the Faculty recently asked the Auxiliary to assist it with the organization of a public meeting and to consider participation in a *proposed* project of the Committees' concerning the distribution of Geriatrics texts.

Glass Will Do!

So far, no silver service has been offered for use at the Building, however, the Woman's Auxiliary will gladly accept candlesticks, bowls, bon bon dishes and trays made of glass. They do not have to be *silver*! The doctors can use them also, of course, whenever refreshments are served.

FINAL DECISIONS REACHED, MAGNUSON REPORT GOES TO PRINTERS THIS WEEK

Capitol Clinic, A.M.A., Vol. 3, No. 49, December 9, 1952

With final decision reached on all recommendations, the President's Commission on the Health Needs of the Nation is sending its report to the printer this week. Release date for the first volume, containing all major recommendations, has been set tentatively for December 18. Release of the remaining four volumes, devoted to detailed testimony and statistics, may be delayed. The Commission, under chairmanship of Dr. Paul Magnuson, has spent a year on the task, holding meetings in Washington and in various cities.

A Commission spokesman emphasized that news stories purporting to represent findings of the report were speculative. He said only Commission members and a few staff people had seen material for the first volume up to the time it was sent to the printers.

Maryland STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 2 *February, 1953* NUMBER 2

EDITORIAL

KEEPING UP WITH ADVANCES IN MEDICINE

A. EARL WALKER, M.D.*

Medical literature has increased so greatly now that it is impossible for any one physician to read all the current journals, let alone, the new medical books and monographs. Even the abstract services of the journals, cannot cover the entire literature, although the Journal of the American Medical Association does review annually some 1200 periodicals. The regular abstracting journals, such as Excerpta Medica which publishes in 15 sections 14,000 pages of abstracts yearly, are of limited help in keeping up with the literature. This deluge of medical literature is particularly felt by the general practitioner who must follow the advances in almost every branch of medicine. But even the specialist finds it difficult to read the dozens of journals devoted exclusively to his own field. For this reason, one of the functions of a state medical journal is to present the recent advances in all fields of medicine.

It is not a simple matter for a journal to give to its readers a clear picture of the advances in medicine. No doubt the frontiers of medicine are being pushed back by research faster now than in any time in the past, but the insurges are not all advances, some are mere forays, some feints and some really retreats. To be able to recognize the real value of a work appearing in a medical publication requires more than a superficial knowledge of the subject. A well written paper giving adequate details may have such poor controls that the reader is misled by the unwarranted enthusiasm of the writer. But often the paper is not a well presented dissertation but merely a preliminary report based on a few cases followed for two or three months; yet on the basis of this experience the authors strongly advocate a new form of therapy. At times the paper is no more than an announcement of what the author is planning to do and what he hopes may be accomplished. Unfortunately such reports seem to appeal to the lay press which publishes the announcement without sufficiently emphasizing the fact that the new therapy has not been proved to be of value to man. Even more difficult to evaluate are the reports which appear primarily in the newspapers or magazines written by "science" writers announcing a new discovery or therapeutic procedure. Such articles, couched in non-medical terms, cannot be critically assayed, are usually premature and over-enthusiastic. But despairing patients seize upon these stories, as a drowning man grasps a straw, and besiege their physicians begging to get this new panacea which they have read about in the press.

---

* Member of the Editorial Board, Maryland State Medical Journal.

While it is the purpose of a state medical journal to keep its readers in touch with the latest developments in all fields, the announcements must be of proved surgical procedures or medical therapeusis. The general practitioner does not have the time, facilities nor background to evaluate experimental procedures. Only the large medical centers are so equipped to safeguard the patient while a new drug or operation is being studied. Patients desiring the benefit of the most recent research techniques of medicine should be sent to such centers. Only when the development has been proved to be of value and its inherent dangers are known—and this may take several years—is it to be used in general practice. This Medical Journal will endeavor to keep its readers acquainted with the latest approved triumphs of medicine so that the health of the state may be maintained at the highest possible level.

YOUR ANNUAL MEETING

BEVERLEY C. COMPTON, M.D.*

On Tuesday, April 28 and Wednesday, April 29, 1953 your Annual Meeting will take place in a somewhat revised form. There are to be papers limited to twenty minutes from 9:30 a.m. until noon, and from 2:00 p.m. to 4:40 p.m. on both days. The evening meetings will follow the usual form of recent years, with a meeting on Tuesday night, including the President's address, and a meeting on Wednesday night following the buffet supper. A record attendance is anticipated.

The following is a list of speakers and the times allotted. Topics have been withheld and will appear in the next issue of this Journal.

Tuesday, April 28, 1953

9:30 a.m. Theodore E. Woodward, M.D.
9:50 a.m. Philip F. Wagley, M.D.
10:10 a.m. Henry T. Bahnson, M.D.
10:30 a.m. Howard W. Jones, Jr., M.D.
11:00 a.m. Robert P. Glover, M.D.
11:20 a.m. Harry M. Robinson, Jr., M.D.
11:40 a.m. Henry G. Reeves, Jr., M.D.
2:00 p.m. John G. Wiswell, M.D.
2:20 p.m. I. William Nachlas, M.D.
2:40 p.m. J. Mason Hundley, Jr., M.D.
3:10 p.m. Thaddeus S. Danowski, M.D. (Harvey Grant Beck Memorial Lectureship.)
3:40 p.m. John Huff Morrison, M.D.
4:00 p.m. Erwin R. Jennings, M.D.
4:20 p.m. George G. Finney, M.D.

On Tuesday evening Dr. Maurice C. Pincoffs will give his Presidential Address. This will be followed by the John M. T. Finney Fund Lecture given by Dr. Robert R. Linton of the Surgical Department of the Massachusetts General Hospital in Boston.

Wednesday, April 29, 1953

9:30 a.m. Milton S. Sacks, M.D.
9:50 a.m. Israel Zeligman, M.D.
10:10 a.m. Gordon E. Gibbs, M.D.
10:30 a.m. William S. Love, M.D.
11:00 a.m. R Adams Cowley, M.D.
11:20 a.m. Philip A. Tumulty, M.D.
11:40 a.m. Noel E. Foss, Ph.D.
12:30 p.m. Louis H. Bauer, M.D., President, American Medical Association, Guest Speaker at Woman's Auxiliary Luncheon, Sheraton Belvedere Hotel. Everyone is urged to attend.
2:30 p.m. David Bodian, M.D.
2:50 p.m. Ruth W. Baldwin, M.D.
3:10 p.m. E. Converse Peirce, M.D.
3:40 p.m. James P. Miller, M.D.
4:10 p.m. Frank G. MacMurray, M.D.
4:30 p.m. Lawrence R. Wharton, M.D.

---

*Chairman, Committee on Scientific Work and Arrangements.

On Wednesday evening there will be a buffet supper followed by a general meeting at which Dr. John S. L. Browne of McGill University, Montreal, will give the Isaac Ridgeway Trimble Fund Lecture.

BUSINESS MEETINGS

Council—1211 Cathedral Street
  Monday, April 27, 1953, 11:00 A.M.
  Tuesday, April 28, 1953, 1:30 P.M.

House of Delegates—1212 Cathedral Street (Deutsches Haus)
  Monday, April 27, 1953, 2:00 P.M.
  Tuesday, April 28, 1953, 2:00 P.M.
  Wednesday, April 29, 1953, 9:30 A.M.

HONOR TO DR. LEWIS K. WOODWARD

Dr. and Mrs. Lewis K. Woodward, Sr., of Westminster will be Maryland's guests of honor at the First Western Hemisphere Conference of the World Medical Association, to be held in Richmond, April 23 to 25, 1953, in observance of the lengthening of life and the constant improvement of human health.

Governor Theodore R. McKeldin of Maryland, in a message received here, told Governor John S. Battle of Virginia of the selection, adding that Dr. and Mrs. Woodward are looking forward to attending the conference. Recently Governor Battle asked each of his 47 fellow-Governors to appoint a physician who will reach the age of 75 during 1953 to visit Virginia and tell of medical advances that have taken place during his lifetime. The invitation included the physician's wife.

Dr. Woodward has been in general practice since 1899. He was born in 1878, the year when pioneering Robert Koch published a history-making treatise on causes of infection, opening the way to rapid progress in various fields of medicine. Dr. Woodward was graduated from the Hahnemann Medical College and Hospital of Philadelphia in 1899 and was licensed the same year.

At the Richmond conference, guests will be greeted by Dr. Louis H. Bauer, president of the American Medical Association, and by leaders of Latin American Medical Societies. Besides scientific sessions, there will be opportunities for visiting historic sites in Virginia, including the 18th century Williamsburg restoration. Expenses of the conference, and of guests and delegates, are covered through a grant by A. H. Robins Co., Inc., ethical pharmaceutical house founded in Richmond 75 years ago this year.—*Arrangements Committee, Diamond Anniversary of Medical Progress, Suite 3201, 444 Madison Avenue, New York 22, N. Y.*

Scientific Papers

SYMPOSIUM ON THE TUBERCULOSIS PROBLEM IN BALTIMORE—PAST, PRESENT AND FUTURE*, [1]

JOHN T. BARNWELL, M.D., *Moderator*[2]

Dr. Moses S. Shiling, Presiding: . . . We had several choices when deliberating about a topic for this general meeting. We could have picked such subjects as arteriovenous aneurysm, pulmonary adenomatosis or histoplasmosis. True, these make for most interesting discussions but we all felt that a panel on Tuberculosis as it affects a practitioner, the specialist, and the various collateral branches of medicine, would still be in order.

We have known the etiology of Tuberculosis for over fifty years and every graduate of the School of Public Health can outline a beautiful and effective plan for Tuberculosis control, and in recent years we have had available bacteriostatic drugs, yet with all this it is still possible for an individual in this day and age, to seek medical attention and not have his Tuberculosis diagnosed until it has reached a far advanced stage, making recovery unlikely. For this reason we have called together representatives of the various groups that have to do with Tuberculosis and have asked them to present to us and perhaps to defend their programs, attitudes and hopes for the future.

At the end of their presentation there will be a question period and I trust you will all send your questions forward. At the end of each row of seats there are little notebooks to use. Send your questions to the center and forward and Dr. Beacham will submit them here. To tie all together, we are fortunate to have as a moderator, Dr. John T. Barnwell, head of the Tuberculosis Division, to the Veterans Administration.

Dr. Barnwell has a distinguished career as an investigator, teacher, and in recent years administrator of a nation-wide group of Tuberculosis Facilities in Veterans Administration Hospitals. This organization has set a pattern for combining medical care and research that could well be emulated by Sanatoria on a state and local level. It is with a great deal of pride that I now turn the meeting over to Dr. John T. Barnwell.

Introduction. Dr. Barnwell: Thank you, Dr. Shiling. You will note that my career did not include any experiences as a moderator. I am not quite sure what my job is; I have never participated in a meeting that quite looked like this on paper before. It reminds me of some meetings we used to hold in Michigan before even a smaller number than this where we did these programs of washing our linen in public. When we get to some of the questions that have already been passed up, I think the panel will have realized what it was facing this afternoon. There are eleven people on the panel and I think you know them all better than I do. We are to start with Dr. Charlotte Silverman, Director of the Bureau of Tuberculosis, City Health Department, Baltimore.

THE ROLE OF THE HEALTH DEPARTMENT

CHARLOTTE SILVERMAN, M.D.[3]

The Bureau of Tuberculosis of the Baltimore City Health Department, the official agency charged with conducting a control program in this city, has been faced with an enormous problem for many years. While it is true that any large city, by its very urban characteristics, is more fertile ground for tubercle bacilli than sparsely populated rural sections, Baltimore has outstripped the other major cities of this country by having the highest mortality rate of them all for a number of years. In this city of approximately one million residents of whom more than one third live in substandard homes, and of whom 24% are Negroes whose opportunities for decent living are infinitely poorer and among whom tuberculosis mortality is four to five times greater than in white residents, our tuberculosis control activities have been similar to those in other communities with perhaps a few additional features.

---

* The Editor wishes to thank Dr. E. G. Beacham for his assistance in the preparation and editing of these papers.

[1] Presented on Wednesday afternoon, April 30, 1952, at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland.

[2] Chief, Tuberculosis Division, Veterans Administration, Washington, D. C.

[3] Director, Bureau of Tuberculosis, Baltimore City Health Department.

Our first function is to accept reports from private physicians, chest clinics, general hospitals and other agencies for persons who have tuberculosis. What proportion of *all* cases of tuberculosis developing each year is represented in the 1400 new cases reported to us annually is not known. But, certainly, we can say that the greater the services rendered to doctors and to their tuberculous patients by the official agencies, the more intense the inducement to physicians to search for tuberculosis and to share knowledge of their cases with the Health Department. When, for example, the Henryton State Tuberculosis Hospital was opened twenty-nine years ago, a considerable increase in reported tuberculosis in Negroes in Maryland was observed.

For the diagnosis of pulmonary tuberculosis, the City Health Department provides the services of four chest clinics in various parts of town. These clinics hold sessions daily, each one of them having one or two evening sessions a week for the convenience of employed persons. Any physician may make referral of his patients to these clinics where chest X-rays, tuberculin tests, and examinations of sputum or stomach washings will be done as indicated and results reported to the referring doctor. These clinics offer follow-up examinations and pneumotherapy for those diagnosed as tuberculous who are without personal physician and who generally have had a period of sanatorium care. Although the practicing physician plays an important role in the initial suspicion or diagnosis of tuberculosis, he has much less to do with the subsequent care of tuberculous persons.

The search for new cases of tuberculosis is a considerable activity of the Health Department. It involves the traditional examining of associates of known cases and the newer means of screening large groups of the general population and the general hospital population. Regarding the investigation of tuberculosis contacts, children have for years constituted too large a proportion of those examined. Of all the tuberculosis cases reported among white residents of Baltimore, only 2.5% occurred in children under fifteen years of age, and yet, children formed more than one third of the total number of contacts examined in our clinics. Negro children, among whom 18% of all tuberculosis in this race was found, comprised 40% of the contacts examined.

Tuberculosis is nowadays primarily a disease of adults, and more than that, an ailment which strikes males past 35 years of age in the greatest number. Yet it is common experience for grown men to offer the greatest resistance to examination because they think it unimportant or are too busy. We shall be much more successful in our search for unknown tuberculosis if adult men can be persuaded that they are at risk from this disease.

In Baltimore for the past few years, over 100,000 persons or 10% of the population have each year received small chest X-rays in mass case finding programs. The City Health Department, with the assistance of the Maryland Tuberculosis Association, yearly takes chest microfilms of about 50,000 persons in industries, communities and schools. Among each 1,000 persons X-rayed, there are found two to three new cases of tuberculosis which are of clinical significance. At *no* time has there been any significant *difference* in the findings *among white and Negro persons X-rayed*, despite the fact that Negroes experience a mortality rate from tuberculosis four to five times greater than that among white persons, and a *much higher morbidity rate.*

The three largest general hospitals in this city have been equipped with photofluorographic units which are used to X-ray the chests of new dispensary patients, old clinic patients on indication, medical, nursing and other hospital personnel. Over 35,000 examinations of this kind are made annually. The Eastern and Southern Health District Buildings of the Health Department are equipped with small film X-ray units which are available for screening purposes, and the Maryland Tuberculosis Association in its central office took over 13,000 X-rays last year as a case finding project.

Once discovered, tuberculosis presents a formidable treatment problem in this community. For too long, we have had only half as many sanatorium beds as are needed in Maryland. Worse still, tuberculous Negroes have had available to them less than one bed for each annual death which is far below the minimum standard of 2.5 beds. Ironically, this critical shortage of beds has been aggravated by improved methods of therapy for tuberculosis. Chemotherapy, improved surgical techniques, expanding social service and occupational and diversional activities have led to more successful treatment, fewer fatalities, fewer irregular discharges, and consequently, fewer vacancies in the sanatoria—with mounting waiting lists.

Because of fearfully long delays in hospital admissions, increasing use of antibiotics for home treatment has been noticeable since the advent of streptomycin and para-aminosalicylic acid. Chest physicians have treated many of their private patients in this way; chest dispensaries in several general hospitals have been prescribing streptomycin and PAS for many patients whom they are following. Clients of the Health Department's Medical Care Program who are found to have tuberculosis are allowed these drugs for home treatment while awaiting sanatorium admission. The public health nurses of the Baltimore City Health Department play a major role in these instances, since in the majority of cases they are called upon to administer the streptomycin injections, or, if possible, instruct an educable member of the family.

The Bureau of Tuberculosis is of the opinion that the discovery of drugs useful in the control of a communicable disease which is a hazard to the public health, casts a new responsibility upon an official agency. Just as the Bureau of Venereal Diseases has made available penicillin and other drugs for the treatment and prevention of spread of venereal diseases, so should the Tuberculosis Bureau be prepared to offer medications to suitable cases who are unable to purchase them and who are many months from possible hospital admission. With this in mind, but with no available appropriations, the bureau put aside a small sum from its regular budget for the purchase of streptomycin and PAS. Since January of this year, it has been possible to put approximately thirty patients, largely from our own chest clinics, on these drugs while they await hospital admission. All of the patients are Negro, since they are likely to suffer the most rapid fatal extension of disease and all were selected on the basis of type of lesion, home situation, and willingness to cooperate. These patients take rest in bed at home and are visited twice weekly by our public health nurses who administer 1 gram streptomycin intramuscularly each time. For each patient, 12 grams of PAS is prescribed daily. It is too soon to speak of results. We have, to date, lost several patients whose disease progressed inexorably in a very brief period of time. Others are clinically improved without X-ray betterment, and still others have shown the most encouraging responses. An eighteen year old Negro boy with massive bilateral bronchogenic spread from a cavity in the right upper lobe and severe toxemia is, after three months of therapy, not only alive but symptom free and now showing beginning resolution of his lesions on X-ray. This boy could not have survived his waiting period of hospitalization without chemotherapy. We are hopeful of being granted increased funds for drug therapy next year.

The grave hospital situation has led to the institution of another procedure to help avoid incurable illness or death. For several years, the Bureau of Tuberculosis has recommended a limited number of patients for direct surgical admission, generally to the Baltimore City Hospitals. Medical abstracts and complete sets of chest films have been sent to the hospital for consideration by the medical and surgical staffs. If agreement is reached, the patients are admitted for lucite ball plombage, thoracoplasty, induction of pneumothorax, etc. This procedure can be employed for comparatively few patients, since even if they are good surgical candidates, they come from poor homes where proper convalescence is not feasible and successful completion of treatment would involve transfer to the Tuberculosis Division.

It is good to report that the end of this year will bring to Maryland new hospital beds which should help appreciably to improve the treatment of the tuberculous. New wings at the Baltimore City Hospitals and Mt. Wilson State Hospital, as well as the new Veterans Administration Facility, will open by the end of this year.

The restoration of the tuberculous to useful living in the community is a vital part of our control program. The Bureau works very closely with the Vocational Rehabilitation Division of the Department of Education in planning for the training and job placement of the tuberculous whose disease is under control. Vocational Rehabilitation does a fine job in a difficult situation, especially difficult with respect to Negroes for whom job opportunities are scarce except for laboring work.

Finally, I wish to comment on our use of BCG vaccine against tuberculosis. We believe that although many questions about this vaccine are as yet unanswered, its value has been demonstrated as an important adjunct to a tuberculosis control program, particularly for persons who may face unusual risk from tuberculosis. We have held regular BCG clinics at the Eastern Health District since October, 1949, vaccinating uninfected contacts of known cases, nurses, medical students and other hospital personnel. As of November, 1950, the Bureau of Tuberculosis and the Harriet Lane Home inaugurated a continuous program of vaccinating all Negro babies born at the Johns Hopkins Hospital. With parental consent, these babies receive BCG before they leave the hospital. Last year more than 1,000 infants were vaccinated. In late 1950, several hundred Negro adolescents in vocational high schools received the vaccine after preliminary screening with tuberculin tests. We hope to be able to resume this program this year.

The outlook for the management of this chronic contagious relapsing disease is better now than it has ever been in this community. With the certainty of expanded institutional facilities in the near future, and the prospect of new improved drug therapy in the form of the isonicotinic acid hydrazide, medical and surgical treatment will be offered more widely and more successfully. Tuberculosis is, however, a disease with deep social and economic roots as well. To implement our medical advances, steps must also be taken to alleviate poverty, slum housing, and the inequities of segregation. A double-pronged attack against this disease is necessary.

DR. BARNWELL: Thank you, Dr. Silverman, and on time, too. I suppose all members of the Panel know they have been given a definite time limit. As Dr. Shiling told you, the questions will be taken up and discussion will be had at the end of the papers by the Panel members. I want to take this opportunity to tell you that Dr. Shiling did a most remarkable job in having every member of this panel turn in a written statement beforehand, which he has timed and I have the time here. Although the questions will come later, Dr. Silverman, I hope you will remember that you can take up one matter that struck me in your paper, it was your distinction between X-ray incidence and morbidity by rays.

Now, the next paper is by Dr. Nathan Racusin, Practicing Physician in Baltimore, and the title of this paper is: "Tuberculosis As Seen By the General Practitioner."

TUBERCULOSIS AS SEEN BY THE GENERAL PRACTITIONER

NATHAN RACUSIN, M.D.

To miss the early diagnosis of an acute abdomen endangers the life of one individual, but only one; to overlook the active case of tuberculosis may endanger an entire family along with an unknown number of contacts. The further tuberculosis progresses also the more severe is the economic impact on the patient and his family when the presence of the disease is finally discovered.

The general practitioner sees in addition to the as yet undiagnosed cases, patients with all varieties and in all stages of tuberculosis. As contrasted with conditions as they commonly existed in the short span of eighteen years ago, it is my belief that we no longer see much active far-advanced tuberculosis in ambulatory patients.

Because of the frequently almost or altogether asymptomatic character of the early stages of certain diseases, notably tuberculosis, syphilis, and diabetes mellitus, routine chest X-rays, STS and urinalysis have over the years been rewarding to the patient and the practicing physician by bringing to light these serious organic diseases.

Factually speaking, in a city like Baltimore with well staffed tuberculosis clinics and Health Department laboratories, the only thing usually necessary for the practicing physician to do is suspect the possible presence of the disease. From there on the diagnosis is almost always made without the necessity of his further intervention on the basis of serial X-rays, sputum examinations, gastric washings and animal inoculation.

Having been a member of the team that diagnosed the active tuberculosis, the physician then has to explain tactfully and honestly and convincingly to the patient and the family the nature of the illness; and to point out the desirability of early specialized treatment, preferably in a sanatorium. At the same time arrangement is made for examination of contacts.

An interesting side light on the present "tuberculosis consciousness" of the public is the increasing frequency with which casual contacts (such as fellow workers) of recently diagnosed cases come to the physician, fearing that they may have contacted the disease.

The part that is played by the general practitioner dealing with tuberculosis concerns, first, the eternal suspicion of its presence in all patients; second, the practice of securing chest X-rays, and where indicated, laboratory studies; third, the removal whenever possible of all active cases to a sanatorium or tuberculosis hospital for definitive treatment; and fourth, the periodic re-checking of close contacts, and all cases believed to be inactive.

In recent years there has been a definite change in the attitude notably of the younger generation toward tuberculosis. The change has been mainly due to continuing education of the public emphasizing the importance of early recognition of the disease.

Instead of the traditional "horse in the burning barn" attitude formerly exhibited by patients with the disease, the majority of those with active disease are now eager to get started with treatment.

Perhaps with the further investigation of substances that show promise in treating tuberculosis the general practitioner may at some future time assume a more active role in treating tuberculosis. But at present, the better advice to those individuals with active disease seems to be "get to a sanitorium as soon as you can."

DR. BARNWELL: Dr. Racusin, I hope when it gets to your name and the discussion later, that you will be willing to discuss the possibility of reports of routine X-rays on the paying customers that go to private physicians. All the reports I know of are on institutional groups which contain large percentages of indigent patients. I'd very much like to know how many undiagnosed cases do escape the routines of the private practitioner when dealing with paying customers.

The next paper is by Mrs. Anita Henson, Public Health Nurse in Tuberculosis Control, Public Health Department, City of Baltimore.

THE PUBLIC HEALTH NURSE IN TUBERCULOSIS CONTROL

MRS. ANITA HENSON[4]

The purpose of the home visit in tuberculosis is for the public health nurse to impart sufficient knowledge about the disease so that the patient and family can act intelligently in care and prevention. In order to be a successful teacher, though, the nurse needs to be informed regarding epidemiology, pre-disposing factors, types and classifications of tuberculosis.

The general functions of the public health nurse in the TB Control Program are to help the family physician or the health department clinic doctor educate the people toward healthy attitudes on tuberculosis and to help make the community, Chest X-ray conscious.

Her functions in the home are to help interpret the diagnosis after it has been presented by the physician-in-charge; to help establish isolation, where indicated; to help set up a simple routine for care and treatment while plans are being made for the hospitalization of the patient; to assist the family make the necessary social and economic adjustments and to help plan for the examination of contacts.

It is the public health nurse who usually notifies the patient when a sanitorium bed is available and she frequently helps arrange for transportation.

During the period of hospitalization, the public health nurse keeps in contact with the patient through communications to the institution and through periodic home visits to the family. During these home visits she encourages the relatives to keep the patient a member of the family unit by writing to him, visiting him and discussing developments at home with him. She also supervises the health and economic security of the family and helps prepare them to receive the patient, without fear of his being a menace on his proper discharge from the hospital.

Because the public health nurse realizes that adequate diet and rest are most important factors in tuberculosis control, she often feels frustrated in her efforts. In every family there are economic problems, of varying proportions, associated with tuberculosis. Poverty engenders crowding, ignorance, nutritional deficiencies and medical neglect; all of which create a favorable soil for the tubercle bacillus.

Poor or substandard housing is occupied by the low income groups in which money paid for housing must be made to give shelter to as many persons as possible; this results in overcrowding of dwellings, especially of the Negro population for whom available housing is usually restricted in Maryland. Overcrowding in turn leads to inadequate provisions for sleep, quiet and the preparation of food. I cite one case, a male TB patient left the hospital against advice. He now lives in the kitchen of his son's three room apartment. The other occupants of the apartment are the son's wife and his five children.

When poor housing has inadequate heating, as is often the case, it tends to crowd the whole household into the better heated portions of the house in cold weather, further creating conditions which lower the body's resistance to disease.

This same low income group suffers basic nutritional needs. Even when the breadwinner is employed, there is frequently not enough money to provide adequate food. If the family becomes dependent upon public funds such as our community offers, the situation usually becomes worse.

Clothing is also a neglected item, even though we realize clothing is important for warmth and protection, as well as for keeping up the morale of patients and families. Many families cannot even afford the basic pajamas, robe, socks and slippers required for State Sanitorium admission.

It is in this type of setting that many of our tuberculosis patients wait for months prior to hospitalization. It is often to this type of home, too, that many of our patients return. Even under the most alert supervision of the public health nurse, new cases of tuberculosis are likely to continue to occur for these two reasons: the infection had probably taken place but was not apparent before the patient was removed; and/or the same predisposing factors remain.

---

[4] Public Health Nurse.

Dr. Barnwell: Thank you, Mrs. Henson. I know Mrs. Henson must think that the Public Health Nurse has too many jobs now and that we'd never have enough Public Health Nurses, but there is one other function I'd like to see them undertake sometime. I hope when I get around to it that you will give me an opinion of that, and that is in their visit to the homes of patients to do the gastric analysis, do they do the gastric aspiration there, before the patient gets out of bed instead of marching him three hours downtown to some clinic before his stomach is washed out for tubercle bacilli.

Now the next on the program is Dr. Leon Hetherington, Chief of Bureau of Tuberculosis, Maryland State Department of Health. "Hospitalization vs. Home Care in Tuberculosis."

HOSPITALIZATION VS. HOME CARE IN TUBERCULOSIS

LEON H. HETHERINGTON, M.D.[5]

The advantages of hospitalization in treating individuals suffering from pulmonary tuberculosis is apparent to any physician who has had intensive training in a tuberculosis hospital where all of the modern and necessary patient services are available.

In the hospital, the diagnosis, prognosis, complete evaluation and planning for the future usefulness of the patient can be arrived at at the earliest interval of time. Under the constant supervision of medical and nursing personnel, symptoms of a minimal character can be detected at the earlier interval and the appropriate steps taken to combat any increase in activity of the tuberculous lesion. Plans for rehabilitation should begin as soon as the diagnosis and evaluation have been completed. The patient can, slowly and safely, be helped to adjust physically and emotionally to his future life.

In the hospital, the social worker serves the needs of those in need of personal help or of those families in need of help. She may be the first to call the attention of the physician to suppression or an early emotional disturbance and thereby secure early consultation of the mental hygienist if the physician in charge confirms her suspicions.

The basis of treatment in tuberculosis is and always will be physical and mental rest and relaxation. It is also much easier for the newly diagnosed patient to observe prescribed rest and regular hours when others in the hospital are following the same or comparable routines. At home, when the physician prescribes rest to the average individual, the patient's conception usually is that intensive rest means "to sleep in" in the mornings, to stop work but possibly not to forgo all of his usual diversional activities. At home, gradually, even if the actual hours of rest are set down in writing, the tendency of the patient is to drift into irregular habits. This is almost irresistable. The attitude of the patient, after minor infractions and when he notes no adverse sympsoms, is an increase in the irregularity and also an increase in his physical activities. He then begins to doubt the necessity of a strict regime of rest. The result is that recovery in these patients may be delayed or the opportunity to recover may be lost entirely.

Needless to say, anyone with tuberculosis who has a positive sputum is a source of danger to others and from a Public Health standpoint needs hospitalization to lessen the dissemination of his tubercle bacilli to others in the home or among his associates.

For those patients in whom the tuberculosis physician believes home treatment will be sufficient, a short stay in the hospital for the education and training of the individual patient would undoubtedly be of considerable benefit. There are occasional patients who do not adjust to hospitalization from an emotional standpoint. These cases must be evaluated by the Mental Hygienist and if he is of the opinion that home care would be more suitable from the emotional standpoint, this recommendation should be accepted if home conditions are suitable; that is, a room alone, no small children, an understanding family or member of the family and sufficient resources for proper food and care. It should, however, be strongly emphasized that these patients are a challenge to the entire staff. Usually there is some problem or problems disturbing this group of individuals and if the social worker, the physician and the nurse can secure the confidence of the disturbed patient so that he will confide in one of them, help may be offered and he may then become a cooperative patient.

---

[5] Chief, Bureau of Tuberculosis, State of Maryland Department of Health.

All cases in need of thoracic surgery should be hospitalized for proper evaluation, diagnostic workup and preparation prior to surgery and for sufficient postoperative period to insure the best medical results. It is, perhaps, not necessary to emphasize that pulmonary tuberculosis is a disease of medical import and that surgery is performed with the medical aspects in mind.

Eligibility for Admission

Maryland is one of nine states in which the means test has been abolished in so far as cost of hospitalization in the Maryland Tuberculosis Hospital is concerned. Tuberculosis occurs more frequently in those of a lower economic scale and to impose charges on this group would hasten the day when welfare support would be required. Financial worries in the past did cause some patients to refuse hospitalization and worries of any type do tend to retard recovery. Where large families are involved, financial worries are quite often of serious import.

In the last year the charges and the amount of money collected for hospitalization in the Maryland State Tuberculosis Hospitals was, in effect, so small that the cost of investigating financial resources would exceed that amount. All legal residents of Maryland are eligible for hospitalization. In addition, at times non-legal residents must be removed from general hospitals, inns, rooming houses, etc., because of the medical and economical need. We put forth our best effort to return this group to the state in which they have a legal residence for hospitalization. Frequently we are unsuccessful and only a small number of states will cooperate in this transfer. There are, also, some "roamers" who have no legal residence and from a public health standpoint, it is necessary to provide facilities for their isolation.

If an individual moves to Maryland, secures what seems to be permanent employment and then develops active tuberculosis, he may be admitted to a state hospital before his legal residence has been established. In this group we are also usually unsuccessful in having the state from which he came assume the responsibilities of hospitalization.

If a patient suffering from tuberculosis moves into this state with relatives or friends in what seems to be a desire for hospitalization in this area we make every effort to return them to their state of residence if hospitalization becomes necessary.

Custodial Care

There are always a number of "good Chronic" cases of tuberculosis; i.e., open infectious cases who are asymptomatic. It is quite true that more "new cases" of tuberculosis occur from contact with this group than from a similar number of active treatment cases who have symptoms. If this type case has a home with no children or very young adults, a room to himself and economically independent, if he is also intelligent, sanitary and cooperative, we will release this group to their homes as maximum hospital benefit cases.

It is my earnest hope for the future when the number of cases needing hospitalization decreases to the point where there are vacant beds in our State Tuberculosis Hospital that the pavilion areas, particularly at Mount Wilson and Victor Cullen Hospital, may be used for this type case in which the home surroundings are not suitable for isolation or if the person is a somewhat uncooperative individual. This would undoubtedly tend to lessen the dissemination of tubercle bacilli and thereby reduce the number of new cases. In fact, at the present time, a very small number of our beds in the pavilions are carrying what could be described as custodial cases.

COMPULSORY HOSPITALIZATION

At the present time, patients suffering from tuberculosis cannot be compelled to accept hospitalization in this state. North Carolina has had a tuberculous prison operating for a period of years which appears fairly successful. One far Western State has recently established compulsory hospitalization for the incorrigible type of individual who is a public menace. The operation of this detention tuberculosis hospital has not been in operation for a sufficient period of time to determine the effects upon the public. To describe it briefly, a patient may be confined by court order for a period approximately six months. If, in a shorter period of time than that, he ceases to be a source of danger bacteriologically, the medical staff may recommend his discharge. At the end of approximately six months, if he has to remain in a tuberculosis hospital and if cooperative, he may be returned to the Tuberculosis Sanatorium from which he came or in his own county. If he remains cooperative there, his cure may continue in the county Tuberculosis Hospital. However, if he again becomes an incorrigible type of individual, he may be returned to the detention hospital. The Tuberculosis Control Officer in that state is of the opinion that this hospital has had a psychological effect upon uncooperative patients. It will, of course, take a period of time to determine just how effectual it is.

I do not know if this state will ever have compulsory incarceration of infectious cases who by their actions are considered a source of danger to those in the public with whom they come in contact. We know that quarantine and vaccination has reduced smallpox until it is almost nonexistent today. We also know that, at present, for each death from smallpox in the United States, there are many thousands who die from tuberculosis. We also know that the chronic case and the uncooperative case disseminate infection to a much larger number than the individual who requires active hospital treatment.

At the present time, there is a law in Maryland which makes it possible, by the preferring of charges by the local health officer in cooperation with the State's Attorney and Judge, to confine to their own quarters open cases of tuberculosis who frequent bars, restaurants and other public places and by their actions indicate their carelessness in ordinary personal hygiene. This has been used on rare occasions.

If compulsory incarceration of the incorrigible type of patient should ever be written into the law, I believe it should be used sparingly. Such a law would need to be written as a protection device to the public and not as a law indicating punishment to any tuberculosis patient. This law would need to be administered from a medical or contagion point of view. It is our hopes in the near future to evaluate, over a period of at least one year, the number of patients leaving our hospitals AMA or AWOL and have the superintendent of each hospital indicate his opinion as to whether these are careless, uncooperative, or incorrigible types of individuals. We will also need the information concerning such types of individuals who are not hospitalized but are located in the various counties and cities and are usually known to the Health Departments of those areas. A great deal of thought needs to be given to the advisability and nonadvisability of compulsory incarceration by the medical profession, by the health officers of the state and by qualified lay members of the public. If such a law is ever proposed, it must contain protection for the individual citizen.

Dr. Barnwell: Does the Maryland Law specifically say "Bars"?

Dr. Hetherington: The Maryland Law says: "Public places like frequenting Bars" they can be declared a nuisance and under that confined to their own quarters.

Dr. Barnwell: It is a most interesting problem. I assumed the State Dr. Hetherington was referring to, was the State of California. That State has a particular place, within the State Prison System. The only place available unfortunately is a place named Terminal Island, that is where those patients go. California also has the difficulty which I suppose you have, of not having enough beds, therefore frequently enough the Courts refuse to order a man into a bed knowing there were willing people waiting to get into a bed. The other system which I think is working much better is in the State of Washington where they have enough beds for all patients. There is a locked ward of twelve beds within that thousand-bed institution, and the presence of those six, seven or eight patients in those twelve beds is enough to keep the other sixty patients who are scattered through the hospital and who have been committed, decent citizens.

Now, the next paper is by Judge T. J. S. Waxter, Director, Department of Public Welfare.

IRREGULAR DISCHARGES FROM TUBERCULOSIS HOSPITALS FROM THE POINT OF VIEW OF SOCIAL FACTORS INVOLVED

THOMAS J. S. WAXTER, ESQUIRE[6]

Dr. William Osler once made the very sage remark that tuberculosis was a social disease with medical implications. At least, he was reputed to have stressed the fact that in the terms of active tuberculosis, the social situation, mental attitude and emotional adjustment of the patient were certainly as significant as the actual therapy used by physicians, nurses, etc.

The employee of the assistance division of a welfare department in a large city is certainly well adjusted to the social implications in the treatment of the tuberculosis patient. In Baltimore, there are a good many families being maintained on public assistance because the bread winner is in a tuberculosis hospital. In the not too extreme instance, the man and wife and, let us say, two children are getting along in a reasonable manner, the man earning some $65 a week, when he finds that he has active pulmonary tuberculosis and must go to a hospital. For the man this means that he is a patient in a tuberculosis hospital carrying the heavy and angry mental load of knowing that his family is living on relief standards. To the wife it means that her income is reduced to a third of what it formerly was and she does not have her husband to share in making the decisions that come up day to day in family living. It is impossible for her not to carry some of this to her husband when she visits him in the hospital.

This burden, added to all of the other conflicts, pressures and attitudes that the patient develops about his health and personal difficulties in general while being in a hospital, makes satisfactory treatment extremely difficult and increases the possibility of an irregular discharge enormously.

Ideally, when the wage earner with tuberculosis goes to a sanatorium, ways and means should be devised so that the wife and children on the outside continue to enjoy the same standards of living that they had while the father was working. There is at least one state in the country, Colorado, where, I am advised, a special fund is available for the family whose need grows out of the fact that the father is in a tuberculosis hospital.

This kind of specialized treatment is pretty difficult to justify excluding as it does the needs of widows and families where the head is in a mental hospital, etc.

---

[6] Director, Department of Public Welfare.

In a way, it sharpens up for the people interested in tuberculosis an interest in the whole matter of standards of assistance. The money which goes to people in need—financial help from the public.

Certainly, in all cases where the family is receiving public assistance while a member of the family group is in a tuberculosis hospital, there should be the closest working relationship between the assistance giving agency and the hospital, etc., and both should plan together the future adjustment of the patient—always with the patient.

I have only mentioned one instance, perhaps an extreme one, where the social situation bears heavily on the patient and certainly interferes with recovery. There are innumerable variations.

I know of a man now in one of the State hospitals who is vitally concerned about the activity of his wife with other men while he is a patient in the hospital. There is the factor of children getting almost completely out of hand as the patient in the hospital has been the parent who assumed primary responsibility for the children. In other words, there are an endless variety of factors on the outside which affect the patient's attitude in the hospital and which are important in terms of recovery and adjustment.

The patient, even upon his discharge, may not be able to go back to the same type of work that he had before his admission and the whole matter of re-training for a lesser job and at a lesser salary may be involved. The variations that can come up are innumerable but they all point to the fact that a greater degree of cooperation between the people in charge of institutional care and social agencies on the outside should be much closer than at the present time.

DR. BARNWELL: Thank you, Judge Waxter. I think the City of Syracuse has made some attempt towards supporting the family also while the patient is in the hospital, and I think some of our South American neighbors have gone way beyond that and do routinely support the family while the patient is in the hospital. The unfortunate part of their law is, it is limited to curable patients and as soon as it is determined this patient is not getting well, he is thrown back into the family. They have some other advanced ideas. They allow their convicts, down there, to take their wives to prison with them.

The next paper is by Miss Myrtle Dooley: "Nursing vs. Nurses." Miss Myrtle Dooley, Assistant Director of Nurses, Baltimore City Hospitals.

NURSING VS. NURSES

MYRTLE DOOLEY[7]

We have heard a great deal about the shortage of nurses in the past several years. The emphasis is placed on the availability of the Professional Nurse, or as she is often called—the Registered Nurse, who has had three years or more preparation. This shortage has always existed in hospitals or institutions caring for patients with tuberculosis and for three very good reasons. First of all Tuberculosis Nursing has not been part of the basic curriculum in schools for nurses, theory has been scanty, and clinical experience almost entirely absent. Secondly, the nature of the disease and the type of treatment offered the patients has not made the field attractive to nurses. Thirdly, the location of the hospitals is usually far from professional activities and recreational facilities. As the Professional Nurse has extended her interest and increased her years of preparation, it is not reasonable to expect her to select an area of nursing where she will be isolated from her own professional group and from other professional groups who now work closely with her. I do not feel that I need to develop these three statements other than to point out that the second, namely the treatment of tuberculosis is undergoing a change. It has been accelerated greatly within the past three years in comparison with the past fifty. However, the recognition of the value of bed rest is still strong within us and the nurse is the key person in the phase of treatment. With the nursing shortage growing more acute, leaders of the profession are coming to the conclusion that the only practical way to get more nursing service lies in using the present nurse supply more efficiently. Almost everybody has found the same practical answer; they hire more practical nurses, attendants, and nurses aides and use them under the supervision of the professional nurse. They work closely with other professional groups in the total care of the patient.

---

[7] Assistant Director of Nurses in charge of Tuberculosis Service, City Hospitals.

We at City Hospitals, Tuberculosis Service, have been working on a program of this kind for the past few years. So far we have been able to take care of patients in bed as long as the doctor feels it is necessary. We have a doctor who heads a team or a group of professional people who are involved in the overall planning and execution of the care of patients with tuberculosis. There is a medical social worker, vocational counselor, occupational therapist, a rehabilitation director, a chaplain, and two nurses. We work closely together. Every Tuesday morning we have a conference. We discuss our mutual problems and responsibilities. The doctor guides us in our work with the patient, outlines briefly the plan of treatment, and starts the plans for discharge. Each member of the team feels free to ask questions and find out just where his responsibilities lie. The nurse and doctor have more contact than any other members of the team. She attends all of the medical clinics where the discussion of medical plans take place. Attendance at the clinics gives her information about her patients with a minimum use of the doctor's time. The nurse must understand these plans for a large part of her work is teaching her patient how to do things for himself, getting him to accept care from others when he does not feel ill, and helping to understand medical recommendations. She is the only member of the staff who sees the patient's family and other visitors and can keep the other members of the team informed about social problems that arise. If she is alert and interested, she utilizes her opportunities in the overall tuberculosis control program by working with the patient's families to have them X-rayed and seek medical advice. Often these activities take more of the nurse's time than doing the routine tasks commonly thought to be her responsibility.

As a member of the second team, the nurse is a teacher and supervisor. She is the head of this team. She plans the bedside nursing care of the patients and teaches the new personnel the routines and procedures. For a number of years at City Hospital we have employed Licensed Practical Nurses for the activities at the patient's bedside. They are nurses who have had one year's training and have been licensed under the Maryland State Board of Examiners of Nurses. They are prepared to give all medicines, carry out treatments, and take care of supplies. The morning following the medical clinic where treatment of patients has been planned, the nurse who attended the clinic discusses these plans with the nurses on the division where the patient is located. She gives them this information in a form they understand and can find their place in it. Insofar as it is possible and helpful, we give these nurses the result of the Tuesday Morning Staff Conference. We not only hold these smaller conferences but once each week all the Licensed Practical Nurses meet to discuss the problems that arise within the department of which they are so vital a part. The next group of workers in this team are the hospital workers. They are made up of men and women who are trained on the job. This is the weakest part of the team, not because we do not recognize the value of their contribution but because so little work has been done to stabilize their jobs, both from the training and the economic aspects. We hope that in the not distant future that housekeeping and diet kitchens will be removed from the nursing service, that ward clerks will be added to the team, and that even a ward manager may be installed as has been the case in some of the more progressive hospitals.

These activities and people mentioned represent our efforts to solve some of our nursing problems in a city hospital tuberculosis service. They leave much to be desired. We feel we have made progress by discussing *Nursing* rather than *Nurses.*

Dr. Barnwell: You know certain hospitals get certain reputations and they are not always exactly what you expect. The thing I have heard most about the Tuberculosis Service in this large City Hospital here is the sacred inviolability of the rest hour. You can imagine the relief and the delight with which I met such a gentle person who has accomplished such a reputation.

The next paper is by Dr. G. Canby Robinson, Director of the Maryland Tuberculosis Association. "Social Service and Rehabilitation in the Treatment of Tuberculosis."

SOCIAL SERVICE AND REHABILITATION IN THE TREATMENT OF TUBERCULOSIS

G. CANBY ROBINSON, M.D.[8]

The successful treatment of tuberculosis is at best a long, slow process, from the time a positive diagnosis is made until the patient is able to resume a normal, independent place in society. Throughout the tedious months or years of medical care, the cooperation of the patient is an essential factor in successful treatment and in order to encourage and foster the spirit of cooperation, patients from first to last must be given careful consideration as individuals. They must be given an understanding of the situation they have to face and must feel that their personal problems are understood and are being given consideration.

The diagnosis of pulmonary tuberculosis almost invariably brings to the patient a variety of social, economic and emotional disturbances which add greatly to the burden of the disease, and which need careful individual consideration in order to minimize their harmful effects on the course of the patient's illness. It is frequently the patience and skill with which these disturbances are studied and treated throughout the various phases of the illness that determine the ultimate outcome of the long battle tuberculosis imposes upon patients and physicians.

It is the purpose of this paper to discuss briefly the plans and provisions for the study and treatment of the personal problems of patients in the public tuberculosis hospitals of Maryland, and to point out the value of what may be called the extra-clinical services in the control of tuberculosis.

The medical social worker has an important part to play throughout the course of the illness. Her service is of much value in preparing the patient to enter a hospital, in helping to meet the problems that make it so difficult to carry out the long period of hospital treatment and in preparing favorable conditions for discharge.

Her study of the patients' social and personality problems, after they are first informed by their physician that they have tuberculosis, is often of much importance in revealing their reaction to the disease and in preparing them for the hospital care their disease demands.

The social worker can do much at the beginning to establish a spirit of cooperation by helping patients to understand the need of treatment and isolation, and by solving some of the problems that may seem insurmountable barriers to their acceptance of the regime they are expected to follow.

Although the social worker can render a valuable service in the chest clinic, where the diagnosis is made in a large proportion of patients receiving public care for tuberculosis, only one such clinic conducted by the Baltimore City Health Department, the clinic of the Druid Health Center, has a medical social worker on its staff, where the social worker is supported by the Maryland Tuberculosis Association.

---

[8] Executive Director of the Maryland Tuberculosis Association.

In the tuberculosis hospitals operated by the State Department of Health encouraging progress has been made in the development of social and rehabilitation services. The State Bureau of Tuberculosis has an experienced medical social consultant on its staff who has had special training in tuberculosis and is responsible for the social service in the Victor Cullen, Mt. Wilson, Henryton and Pine Bluff Hospitals. A professional social worker has been secured for Henryton, the hospital for Negro patients, and two social workers have been assigned to the Mt. Wilson Hospital by the Whear Ridge Foundation. A new worker is to join the staff at the Victor Cullen Hospital in July.

Social workers interview the patients soon after their admission, study their emotions and personality, discover their social and economic problems and endeavor to clear up the circumstances that may interfere with their ability to relax and rest in mind as well as in body. Patients need help in adjusting to the new surroundings and routine of the hospital, in order to get the full benefit of its service, and the social workers take a leading part in this process.

The extra-clinical services are conducted by a team of professional workers, consisting of occupational therapists, librarians and vocational rehabilitation counsellors, who coordinate their activities with those of the social workers.

At the Victor Cullen Hospital an occupational therapist and his assistant conduct work shops for men and women, teaching handicrafts, typewriting, dressmaking and home management to ambulatory patients. Other forms of constructive work are provided for bed patients. Similar activities, on a more restricted scale, are carried on at Henryton. At Mt. Wilson a part-time occupational therapist, supported jointly by the Baltimore Tuberculosis Aid Society and the Maryland Tuberculosis Association, has developed a successful service which has given bed patients opportunities to carry on stimulating and diversional art and craft work, to which the patients and the staff have responded with interest and appreciation.

Patient libraries, conducted by full-time professional librarians, have been organized in the Victor Cullen and Henryton Hospitals through the cooperation of the Maryland Tuberculosis Association and the Library Extension Division of the State Department of Education. These librarians spend a large part of their time with the patients, not only supplying them with suitable reading material, but also encouraging and guiding their reading in preparation for future occupations and in developing new interests of lasting value.

Vocational rehabilitation is made available to tuberculosis patients by the Rehabilitation Service of the State Department of Education. The State hospitals are covered by a Counselor, well trained in the field of tuberculosis, who has done much in developing the work shops and occupational opportunities in the hospitals.

Whenever the patients show sufficient progress toward the completion of their hospital care, their occupational possibilities are studied and a plan is made in relation to their medical prognosis and potential physical ability. Their aptitudes, desires, social status and past occupational history are given careful consideration, and when indicated, training in fields of work best suited to their individual needs is arranged by the Rehabilitation Service. This training, provided by State and Federal funds, usually leads to successful employment, which is supervised by the Service.

During the year ending July 1, 1951, 126 tuberculosis patients were trained and placed in suitable employments, by which they were made self-supporting. The cost of this training was $36,000.00, while the salaries and wages they were receiving on July 1, 1951, aggregated $142,000.00 a year. These figures indicate the economic value of this Service, as undoubtedly without it, many of these patients would continue to be public charges, to be supported by their families or to be living on resources they had not earned.

Social workers, occupational therapists, librarians and rehabilitation counsellors work together as a team, and participate in planning the medical care of patients. They take part in the clinical conferences in the hospitals and their services are thoroughly accepted and intelligently used by the medical and nursing staffs.

It has been interesting to watch the definite changes and improvements in the care of patients that have recently taken place in the State tuberculosis hospitals. The development of social service and rehabilitation has been an important factor in these improvements, and have undoubtedly helped to lessen the number of patients leaving the hospitals against medical advice, by creating a better understanding and cooperation between patients, doctors and nurses which adds greatly to the efficiency of treatment.

The same developments of the extra-clinical services are going forward in the Tuberculosis Division of the Baltimore City Hospitals, where there has been a striking decline in the number of patients leaving against medical advice, which is concrete evidence of progress. These services will be more fully developed when the new 300-bed addition is opened there, and a similar expansion will undoubtedly occur with the opening of the splendid new building at Mt. Wilson within a few months.

The present situation in regard to the social and rehabilitation services in all of the public tuberculosis hospitals in Maryland is promising, but only a beginning has been made. The present personnel is much too small in numbers to meet many of the social needs of patients, but a demonstration is being made of how these needs should be met, and the value of these services in the medical care of tuberculosis.

The Maryland Tuberculosis Association is much interested in these services to patients, and has for several years expended a considerable portion of its Christmas Seal Sale funds for their development. The Association has endeavored to exert leadership in this field, as it is convinced that they have a valuable contribution to make, not only to the care of individual patients, but are an important element in the program for the control of tuberculosis.

DR. BARNWELL: I always found Dr. Robinson helpful to the Veterans Administration in establishing a 300 bed hospital in this city. I hope he, the members of this panel and the members of this audience will help us in integrating that hospital into the facilities of this community as a hospital for diagnosis, treatment, teaching and research and prevention. We may seem to have some advantages in a hospital of that sort, particularly in physical facilities, and I'd like you to know one handicap that the Veterans Administration feels it had and that is that while we try to integrate ourselves into the community's facilities, we must realize that we are dealing with the control of Tuberculosis within a segment of the population. We stand to lose in the same way that industry lost when it attempted to control Tuberculosis in miners, that is, the men who actually went into the mines, and soon found that unless they or somebody else controlled Tuberculosis in the home, no one could control Tuberculosis in a given segment of the population.

The next paper is by Dr. Philip Sartwell, Associate Professor of Epidemiology, School of Hygiene, Johns Hopkins. "The Effect of Improved Therapy on the Sanatorium Bed Situation."

THE EFFECT OF IMPROVED THERAPY ON THE SANATORIUM BED SITUATION

PHILIP E. SARTWELL, M.D.[9]

Most physicians will agree that premature sensational claims for a new treatment, especially in such diseases as tuberculosis or cancer, are unwise and may even do serious harm. The recent claims in the lay press for the newly developed drugs, isonicotinic acid hydrazide and its analogues, were of this sort. One of the chief dangers, is that agencies responsible for tuberculosis control may decide to reduce their appropriations and activities, such as the provision of sanatorium beds.

Now the truth of the matter is that if the new drugs are similar to streptomycin in their action but more effective, sanatorium bed requirements are not likely to be diminished but may actually increase. This statement is predicated on the assumption that it will still be advisable to treat pulmonary tuberculosis in a sanatorium. The basis for this belief can be seen if we examine the rates of discharge and death at a sanatorium and observe the effect of changes in these rates.

Dr. Frank Weber has recently made a study of irregular discharges from a Maryland sanatorium for Negroes, covering a three-year period from January 1, 1948, to December 31, 1950. The probabilities that patients admitted in the first two years of that period would die in the sanatorium or be discharged either with or without medical approval have been calculated for each time period after admission. At this particular institution, it is to be expected, based on this experience, that at the end of two years following their first admission, 51 per cent of patients will have died, 20 per cent have been discharged without medical approval and 13 per cent discharged with consent of the staff. The median duration of stay was 6½ months.

Now let us suppose that the efficacy of the new drugs will be such that the risk of mortality among patients in sanatoria in all stages of treatment is reduced exactly one-half by the new treatment. We will further assume that the likelihood of a patient being discharged with a successful outcome, that is, of being discharged with medical approval, is doubled and that the frequency with which patients leave the institution against medical advice is unaffected. Let us apply these altered probabilities to the experience of this sanatorium. We find that by cutting the sanatorium mortality in half and doubling the probability of medically approved discharge, the median length of stay of patients from the time of their first admission would not be diminished but increased from six and a half months to over eight months. The earlier experience was that 16 per cent of patients were still in the institution two years after admission; under the new conditions this proportion would actually be increased to 21 per cent. The reason for this, of course, is that our therapy will have prolonged the lives of many patients admitted in an advanced stage, who constitute a large proportion of admissions, and of patients with disseminated forms of tuberculosis, who in an earlier period would have succumbed rapidly after admission. In other words, a subacute disease is converted into a chronic one. I am told by clinicians that this has been the observed effect of streptomycin therapy and that as a result sanatorium waiting lists are now longer than previously. It may be expected that the new drugs, if effective, will accentuate this trend rather than diminish it and that the need for sanatorium beds in this area will continue to exceed their number for years to come unless, of course, our therapy leads to almost immediate cure of the disease, which is most improbable. In addition it may be expected that the number of patients needing thoracic surgery will increase.

---

[9] Associate Professor of Epidemiology, Johns Hopkins School of Hygiene.

Ultimately the declining morbidity from tuberculosis can be expected, if present trends continue, to bring down the requirement for beds. To await that day complacently, however, would be most unwise. In the past no strictly therapeutic measure has alone been shown to be capable of controlling the incidence of a communicable disease. Protection of the public against dissemination of tuberculous infection is a highly important function of the sanatorium, as important as it has ever been in the past.

DR. BARNWELL: The next paper is that of Mr. Harvey Weiss, Superintendent, Sinai Hospital. "The Role of the General Hospital in Tuberculosis."

THE ROLE OF THE GENERAL HOSPITAL IN TUBERCULOSIS

HARVEY WEISS[10]

The fact that tuberculosis is one of the oldest known diseases and the fact that it is so widespread is certainly not news, at least to a group of this type. These facts are only restated to remind ourselves that during these long years our concepts in the treatment and management of tuberculosis have changed many times.

While today the medical treatment of tuberculosis is primarily considered the function of the special hospital, the general hospital is beginning to play a more important part in the over-all problems of its management. This development is a natural one, when we consider general trends in medical care. We are still operating in the throes of specialization in all branches of medicine, but more and more the pendulum is swinging towards generalization. True, it is slow, and where it will stop cannot be too accurately predicted, but we do know medical centers where specialization and generalization can be practiced together are being rapidly developed in various parts of the country. More and more our thinking is beginning to crystallize on various factors which favor bringing the tuberculous patient closer to, if not into the general hospital.

The factors which are making us think of this relationship are many, and all of them need to be studied and weighed before coming to a definite decision. At the same time, these factors cannot be ignored in the efforts of a community to solve its problem in relation to tuberculosis. Briefly, some of these factors may be stated:

1. The general hospital is the greatest depository for acute illness.
2. As such, it is the place where the diagnosis is made.
3. In order to make the diagnosis, it must provide the special ancillary facilities such as clinical laboratories, X-Ray laboratories, trained medical, technical and professional personnel needed to achieve this purpose.
4. The general hospital is the training center for all types of professional personnel such as medical, nursing and other groups.
5. It is the largest reservoir for the diagnosis of cases of special diseases such as tuberculosis.
6. It is best fitted to manage the surgical treatment of tuberculosis.
7. The general hospital is usually located in the larger population areas where all types of personnel are more readily available.

There are other factors. I have cited enough to point out that the general hospital must, because of its modern functions, play an important part in the care and treatment of tuberculosis.

If we accept the medical center plan which embraces a physical union of the tuberculosis hospital and the general hospital, we are talking about the ideal situation as we see it today. However, for the present, this ideal arrangement will only prevail in most instances in communities which already have them, or where new hospital planning and construction are taking place. In the application of the Hill-Burton Act for financial aid to states for hospital construction, tuberculosis divisions in general hospitals are given top priority. As a result, many installations of this type are being built. Until this program is more fully developed, the general hospital can ill afford to shut its eyes to cases of tuberculosis.

---

[10] Superintendent, Sinai Hospital, Baltimore, Maryland.

There will always be cases of tuberculosis in a general hospital, even though some of them are not diagnosed. The general hospital should recognize this fact and become a member of the team by adopting well established procedures so necessary in the over-all program in controlling tuberculosis:

1. Pre-admission chest x-rays for in-patients.
2. The same chest x-rays for out-patients.
3. Chest clinics which are teaching clinics.
4. Follow-up clinics.
5. Teaching of isolation techniques to Medical House Staff, Nurses, Dietitians, etc.
6. Establishment of Medical Social Service Departments.

All of this can be done without being physically connected to a special hospital.

This is one of the ways the general hospital can prepare itself for the time when tuberculosis divisions will become integrated parts of general hospitals, if this be the accepted practice.

Dr. Barnwell: I will be interested to see what that priority in the Hill-Burton Act will do. We have a priority in the Veterans Administration also but priorities do not overcome prejudices.

The next paper is by Dr. Vernon Langeluttig, Assistant Professor of Medicine, University of Maryland, Medical School. "Teaching of Tuberculosis in the Medical School."

THE TEACHING OF TUBERCULOSIS IN THE MEDICAL SCHOOL

H. VERNON LANGELUTTIG, M.D.[11]

The subject of this presentation has been studied by various groups over a considerable period of time. The latest study of this kind was that of the "Council on Undergraduate Medical Education"—a committee of the American College of Chest Physicians. The report of this committee appears in the March issue (1952) of Diseases of the Chest. There is very little that I can add to their findings, however, there are certain impressions which I have gained in my experience, both as a teacher of diseases of the chest and as a clinician.

It is generally agreed that the teaching of tuberculosis and diseases of the chest have been lackadaisical in many respects. The Council, in an endeavour to determine the methods and amount of teaching done in tuberculosis, sent questionnaires to all medical schools in the United States and Canada. From the replies received the following pertinent facts were discovered:

1. In some institutions there was a dearth of teaching material because of the absence of tuberculosis sanatoria, or there was poor co-operation between existing sanatoria and the medical schools.

2. In some schools students are given assignments in textbooks of general medicine and physical diagnosis. The implication here, of course, is that such texts are usually very much out of date and thus grossly inadequate to a proper knowledge of the subject.

3. Many teaching hospitals are completely adverse to admitting tuberculosis patients and thus neither medical or nursing students have any contact with the disease.

---

[11] Assistant Professor of Medicine, University of Maryland Medical School.

4. In a few schools the teaching of tuberculosis is frowned upon for reasons considered legitimate because of prevailing conditions.

5. In some instances the subject is taught as part of the general medical course, and, by volunteer lecturers. (This latter point is given much stress.)

In my opinion there are a number of reasons for the neglect of this most important phase of our medical educational program:

1. There exists a general feeling that, since tuberculosis is a disease usually treated in city and state institutions, there is little for the practitioner to do except refer suspected cases to the sanatorium or local tuberculosis clinics.

2. The feeling exists, and I personally have heard it expressed by competent authority, that the disease itself takes such a high toll of students, internes, and nurses, that practical work in tuberculosis wards should be abolished, and all contact by students be avoided.

3. The fact, that in general, the subject of tuberculosis has been taught for a long time as a part of the general medical lectures, and usually by one who is not a specialist in this field but a general medical man.

As regards item #1, it is a certain fact that much valuable time is wasted in already overcrowded sanatoria by the lack of knowledge of the disease and its differential diagnosis. Too many non-tuberculous cases are mistakingly sent to the sanatorium when they really belong in the acute hospital. The graduating student should by all means have a good working knowledge of the simple diagnostic procedures, such as sputum and gastric examinations, tuberculin tests, and also the value of the more technical and skilled procedures, such as bronchoscopy. Inasmuch as there are upwards of seventy pulmonary conditions which must be differentiated from tuberculosis, the study of all diseases of the chest must be emphasized to a greater degree, and as our knowledge increases and our temerity in exploring the chest surgically is lessened, this greater emphasis becomes more and more important. Also, without some understanding of pulmonary function and function tests the pitfalls of modern therapy may well be overwhelming. Students must have some basic knowledge of these facts and they must be incorporated in the curriculum.

With respect of item #2, the argument that teaching along practical lines, requiring work in the tuberculosis ward, is fraught with so much danger to the medical student and the nurse, would if followed to the letter, leave us without anyone to take care of the tuberculous. This type of specious argument has already made itself felt to the detriment of our sanatoria and hospitals. Most phthisiologists are well aware of the difficulty in obtaining internes and nurses because of the fear of contracting the disease. In my own experience most of the internes and nurses who have contracted tuberculosis have done so from contacts in the general hospital, in the accident room, in pathology, and on the general wards, especially surgical. Proper teaching and indoctrination should overcome this danger since these professional people should know how to protect themselves. We do not prohibit visitors in our tuberculosis wards.

The third item needs very little explanation. The broad field now covered by diseases of the chest makes it almost mandatory that the subject be treated as a specialty in itself, and since tuberculosis is the principal condition encountered which must be differentiated it must be included in the broad field and its various manifestations understood. As has been mentioned before, surgery of the chest has opened up the broad field of pulmonary function studies and therefore something new has been added which will require further investigation. All this cannot be done in the old slipshod manner if progress is to be made.

There is not time enough here to give in outline what subjects must be covered in order to meet the requirements of a comprehensive study of diseases of the chest, but such an outline is available to anyone interested. The report of the Council has taken this step and further has published a manuscript on "Teaching Diseases of the Chest in Medical Schools"—Journal of the Association of American Medical Schools, May 1951.

Dr. Barnwell: Thank you, Dr. Langeluttig, I hope that report which you report is not based on a questionnaire. I mistrust questionnaires anyway, and one on this subject addressed to the Deans of Medical Schools I particularly distrust.

The next speaker is Dr. Elmer P. Sauer, Medical Director of the State Tuberculosis Hospitals. I have the same difficulty in introducing Dr. Elmer P. Sauer as I did Dr. Hetherington. I suppose you know the State of Maryland stole them both from the Veterans Administration. "Tuberculosis Treatment: Past, Present and Future."

TUBERCULOSIS TREATMENT: PAST, PRESENT AND FUTURE

ELMER P. SAUER, M.D.[12]

To summarize briefly one might say that in the past the treatment was not too good, today it is fair and in the future we hope it will be good.

Past

In the past, the dominant theme was that tuberculosis could not be successfully treated. Trudeau caused a significant advance when he advocated the use of rest rather than strenuous outdoor exercise. During rest, it is possible for the body to best utilize its defenses against infection. Sunshine, in large doses was proven harmful. Freezing cold in the past was considered necessary. I can see no virtue in being frozen and I can speak from personal experience. I always felt that only the strong and hardy could survive a northern winter in a sanatorium. Cold always was a good preservative for the tubercle bacillus but not for the human tissues. In the past, distance seemed necessary for treatment. As a general practitioner, I often wondered if the far-away program was not suggested because the doctor felt that treatment was hopeless and the further away the patient was, the better. Altitude, as expressed in mountain heights, has no virtue as such. The stethoscope was extensively used for diagnosis. Early diagnosis was almost impossible due to difficulty in interpretation of findings and the fact the signs usually appear late in tuberculosis.

Present

The foundation for present treatment still lies in rest and good food. We feel this can best be given in the hospital. We feel that here the tuberculous cases can be concentrated and that care can be specialized. The tuberculosis hospital of today, using both surgery and medicine, is very similar to any general hospital. It is essentially a chronic infectious disease hospital. There is no social stigma in the hospital, that some people feel when at home in the Community. The active case is taken from the home to break the possibility of further spread. Much can be learned about the proper care for tuberculosis. Each patient has a common problem. The hospitals are often built near home so that visiting can be made easier. A person in bed for a long time, away from family, is prone to walk out before treatment is adequate unless he has visitors.

Today, mortality is less but morbidity remains high. In other words, we today are finding many new cases but fewer are dying than in the past. In 1900 where eight would die, today only one would die. The declining death rate is not due to medical advance only. Better housing with less crowding, better food, better case-finding and better education, as well as better medical treatment, are all factors. Very little of bovine tuberculosis is seen today because of pasteurization and tuberculin-testing of cattle. Young people especially women, and older men, constitute the largest part of the case load. Today, we feel that tuberculous cases can get well; especially if seen early. The use of X-ray for screening purposes enables us to find the disease earlier than with the stethoscope.

---

[12] Medical Director, Maryland Tuberculosis Hospitals.

In the hospital, the treatment is by a team of which the logical leader is the doctor. He must direct the plan of action and vary it as needed. The patient is separated from the community until it is safe to return. Direct sputum examination in the past was considered accurate enough for dismissal of the patient home but today the much more sensitive culture has replaced the guinea pig. It is less cumbersome and much cheaper. General medication is frequently given. Examples are as follows: Cough is lessened by the use of Codeine or one of its substitutes. Hemorrhage usually quiets if cough is lessened and the patient is inactive.

Of the recent drugs effective in treatment, Streptomycin (an antibiotic) is most effective; especially when combined with PAS (para-amino-salicylic acid). If Streptomycin is given intramuscularly two or three times a week, there is little toxicity. PAS is given orally about 10 to 12 grams a day in divided doses. The two drugs used as a unit are much more effective than either alone. Treatment can often be continued for long periods. Occasionally, these drugs have been used for a year or even more. This treatment is useful for both pulmonary and extra-pulmonary tuberculosis. While on this treatment, it is frequently difficult to find a positive culture but when the treatment is stopped, the organisms may grow again. Tibione, one of the drugs of the sulfa series, has found a very limited usefulness. The drug is only slightly effective and very toxic.

Before speaking of any of the newest drugs, may I comment briefly. To really get the latest news on new drugs, watch your daily newspaper. We, in the hospital, are accustomed to start ward-rounds only to be beseiged by patients who want the new drug mentioned in the morning or evening paper. Lately, the newspapers are announcing first and the medical periodicals following. Much of this publicity seems unfair to the patient and doctor, unless one believes variety is the spice of life.

Isonicotinic-acid-hydrazide, a relative of Tibione, appears to be the latest of these new drugs announced. We are using it on a very limited scale and cannot yet say where it will fit into the treatment pattern. It can be given orally and should not be too costly. A drug of this type is needed.

Mechanical rest for the lungs has been used for a long time. Before any treatment is started, a long-range program is laid out whereby many procedures will be used so that the patient will get well as quickly as possible. Rest, collapse and drugs frequently prepare the formerly hopeless case so that excisional surgery can finally be employed.

A brief summary of collapse procedures might be as follows:

1. Pneumothorax is little used now. Probably not over a dozen cases were started in all Maryland State tuberculosis hospitals last year. Too few cases were eventually successful and the complications were too many.

2. Pneumoperitoneum: This has largely replaced pneumothorax as it is safer and easier to use.

3. Phrenics are seldom used as we feel the possibility of loss of useful lung tissue is too great a hazard.

4. Thoracoplasty is a good collapse procedure but the patients often object to the pain and mutilation if the procedure is extensive.

5. Extra-pleural prosthesis may be used; depending on the operator.

Excision. There has been a marked swing in this direction in the past few years. Large caseous masses into which antibiotics have difficulty penetrating can be removed. Cavities, bronchiectatic areas and stenotic bronchial lesions can be removed. Often, after the resection, it is necessary to fill the lung space and prevent overdistension of the remaining lung. Here, tailored small thoracoplasties are frequently used. Let it be emphasized that not all the diseased tissue can be removed. Whether it be thoracoplasty or resection, a long period of bedrest, with or without antibiotics, is needed before the lesion can be brought under complete control. Unless the patient can be returned to the Community as a useful citizen, we do not feel a good result has been obtained.

Initially, the patient is started on bedrest and this is modified as he is physically able to be more active. Many patients are worried. The Social Worker can frequently help with the problems in the hospital or at home and, thereby, relieve some of the worry. Radios, television and movies help pass the months or years. In the latter part of the program, the patient's activity is gradually increased. This is to test the stability of the chest lesion and to ready him for the time of discharge. Here, it is possible to add occupational therapy and *especially* rehabilitation. Many of these people come from the heavy manual-laboring classes and if it were possible for the patient to do more suitable work, there would be less likelihood of a break-down. To teach the housewife easier ways to do housework and ways to prepare better food is rehabilitation and is important. After discharge, the private doctor or clinic takes over the care of the patient.

FUTURE

As for the future: Today, it is possible to look at the past and see its mistakes and, in the future, it will be possible to look back and smile at today's errors. Until we have more knowledge, we must do the best we can with what we have. Frankly, today we do not have a completely satisfactory treatment for tuberculosis. A treatment that will give quick results, easily and surely, without too great a cost is what we dream about. When good medicine is found, the use of collapse therapy and surgery should decline. In the final analysis, I feel tuberculosis will be a disease with medical treatment. Our new 300-bed hospital is being built with the idea in mind that if the Utopia of treatment is found, the new structure can be easily converted to other use. A good case-finding program will always be needed until the incidence of tuberculosis becomes negligible. If this occurs, then it will be necessary that our neighboring nations achieve a like goal if we are to remain free from the disease. It is even possible to dream of a race of people who will have no resistance because they have not been exposed to tuberculosis for many thousands of years. This happened to the South Sea Islanders and, when tuberculosis was introduced, a very acute violent and fatal disease resulted. The present problems are too pressing, however, to dream so far into the future. What we need now is a cheap, orally-effective bacteriocidal drug.

DR. BARNWELL: Thank you, Dr. Sauer. You have heard eleven papers, they are only six minutes overtime, that overtime is due entirely to the moderator venting his prejudices. I'd like now to call for questions to the panel. May I call upon the members of the panel to read the questions which were previously sent in and have them give us their answers. First I'll call on Dr. Silverman.

(*Continued on next page*)

* * * * * *

CREATIVE ART SHOW

Annual Meeting

Calling all doctors and wives!

Now is the time to start planning your exhibits for the show Monday, April 27 until Wednesday, April 29, Annual Meeting, Medical and Chirurgical Faculty.

QUESTION AND ANSWER PERIOD

Dr. Charlotte Silverman: The first question is this:

Question: Do you think the time is right for a city-wide X-ray survey as has been done in Washington, Los Angeles and Boston (and I might add about a dozen other cities)?

Answer: I have mixed feelings about this. If we were to do this in Baltimore, it would mean trying to get a major portion of our population over the age of fifteen. It would come to perhaps four or five hundred thousand people, about the number that were done in Washington a few years ago, and we would attempt to do this within a period of several months. We would probably find about eight or ten times the number of cases in that period of time that we find in a whole year now. I don't think that the hospitals could conveniently take them in quickly, but of course it is important to find cases and institute treatment at home. This is an expensive venture and I just throw out the idea that the amount of money involved—Washington estimated it cost them about $250,000—might perhaps be spent in other aspects of Tuberculosis control that are of a more dynamic and continuous nature. I personally favor much wider and closer investigation of associates in Tuberculosis cases and a much greater expansion of a vaccination program.

Question: What are the active figures of the Tuberculosis waiting list at present?

Answer: We have about two hundred residents in the City of Baltimore waiting to go into the hospital. This compares very favorably with the situation as of the first of the year when we had about three hundred. But a great many have been taken into the State hospitals and the new wing at Henryton has relieved the situation a great deal.

Question: (This was asked with tongue in cheek, I would think, or else simply to press me to a dreadful answer.) What is the longest time an active case has had to wait or is now waiting Sanatorium admission?

Answer: A year ago one of our nurses sent me a private special delivery note saying "happy anniversary" for a particular patient who had just that day celebrated his first anniversary on his Sanatorium waiting list. Our longest experience has been about fourteen months and that has been quite long. A year has not been unusual, and nine months is very common, and a number of our patients now are getting in who were put on lists last July and August.

Dr. Barnwell: It is a common thing in some areas. The Veterans Administration has had as many as five deaths on the waiting list within a period of six months. Now, I'll call on Dr. Racusin.

Dr. Racusin: The question that has been asked is, "How do you handle the positive sputum patient who has a long waiting period before being admitted to a Sanatorium?

Answer: Well, frankly, that is rather a headache, medically speaking. We try to keep the people at rest in bed. We enlist the aid of the public health nurse to come in and supply the individual with material such as sputum cups, etc., etc., also to enlist their aid to try to teach the family how to observe isolation precautions as best they can. But from what has been brought out previously by other speakers, the patient who left on his own is notoriously lax with regard to keeping up the instruction that he has received. Also the morale of that individual suffers noticeably because in the first place, after having been assured that prompt hospitalization is important and having gone to lengths to be honest with him and to tell him what the outlook is in the disease, he then throws at you in your face the advice that you gave him several months previously: "If all this is so important why the heck do I have to wait so long?" This, of course, results usually in a certain amount of loss of face by the physician in attendance, who in turn takes it out on the authorities by plaguing and pestering. . . . I see Dr. Hetherington laughing, I've worked on him many, many times in the past, plaguing and pestering the City and State authorities to try to get beds for these individuals. Many times, particularly when it is a breadwinner in the family who needs the bed, we have all the other sociological implications, such as the family having to go on relief. It is rather a dismal problem at the present time. Of course we all hope once we have more Sanatorium beds the situation will be corrected, but briefly, that is the way we have been handling it.

Dr. Barnwell: Now we will hear from Mrs. Anita Henson.

Mrs. Henson: My question is: Do all Public Health Nurses spend some time in a Tuberculosis Sanatorium?

Answer: Assuming that means as a worker, the answer is "no"; not at this time. However, the Public Health Nurses do attend the team conferences that were mentioned by Miss Dooley, the conferences that are held in the hospital in regards to the care and the probable discharge of the patients. The Public Health Nurses do occasionally make personal visits to the patients and have conferences as often as necessary with members of the staff. I might add that in some areas the need has been seen to include a Public Health Liaison Nurse as a part of the hospital staff, and there is a possibility that trend will extend to this area in the not too distant future.

Dr. Barnwell: Mrs. Henson, would you answer my personal question for my personal information?

Mrs. Henson: About the Public Health Nurse making provisions to have a gastric at home? Well, so many new procedures have been added to the Public Health Nurses' routine that I suppose that would be added before long. The nurse could assume that responsibility if it were planned accordingly.

Dr. Barnwell: Now Dr. Hetherington, your question?

Dr. Hetherington: Am I allowed to comment on some of these others before I answer my question? Well, I think in all due respect to those present, we should clarify and explain this waiting list a little bit as it exists at the present time; yesterday I counted the waiting list of the State Tuberculosis Hospitals and I presume that most of those cases on the City waiting lists are also on the State waiting list. Those lists of course are kept separately. As of yesterday there were two white females on the waiting list, one of those is a patient out in Denver, Colorado, too ill to be transported back to Maryland; and the other one came on the waiting list yesterday, so we are very close up on the existing white female waiting list. For the colored female waiting list since we've been able to open a new wing at Henryton, and reopen the floor which had to be closed down due to construction above that floor, there are presently thirteen colored females on the waiting list, which means less than a month old. We had as of yesterday forty-three (43) vacancies at Henryton, about thirty-some of those being colored females which would mean that we are going to have vacant beds at Henryton for a period of time in the female class. With this in mind we have been in conference with the City officials during the past two or three weeks to see what arrangements if any can be worked out to equalize the female and the male colored waiting list since there are approximately one hundred and five on the colored male waiting list. As of yesterday there were eighty-five (85) white males on the waiting list. Now that is much better than we were several months ago, and to bring you up to date, we are admitting presently from the January class, I might say, in the white male waiting list. The colored male waiting list, due to the close-down at Henryton, due to the close-down at City Hospital for new construction, shifting around, etc., we are admitting late September or early October class and we do hope there can be some equalization so that there will be considerable slack taken up. I can say the waiting list is much shorter now than it has been for many, many months. The morbidity continues. The mortality rate in Maryland in 1945 was sixty. The provisional mortality rate for last year is 29.7, so that we are going to catch up some of these days. We cannot go on building beds, beds, beds, until we are able to staff them and there has to come at some time an equalization point. Now, my first question:

Reverting for just a moment to the question on Nurses, this is my own personal sentiment. I do wish every Public Health Nurse had a period of time in a Tuberculosis Hospital. You can go to the hospital for your conferences which is somewhat similar to tea—I'm not accusing you of drinking tea, but in comparison to the experience that you gain, it is something that is absolutely worthwhile and would be of benefit to all of us. Now, my question.

Question: Do you recommend drug therapy for active cases awaiting Sanatorium admission?

Answer: The answer to that is yes and no. There are a certain number of cases in whom by proper selection I believe the drug could be substituted in the home as a part of the long range plan. There is no one thing in Tuberculosis that is going to effect the cure. You have to effect a plan for each case. I have not quite reached the point where I believe that drug therapy should be given to everybody universally.

Question: My second question is: Do you think it is the responsibility of the Federal Government to arrange for or subsidize the care of the Tuberculosis transient who has no legal residence?

Answer: I'm going to give you a very definite, emphatic NO. Maryland has at the present time three displaced persons hospitalized under the care of the taxpayers of Maryland. The Federal Government after they come in assumes no responsibility. The oldest one of that group being in Maryland a period of six months before hospitalization was necessary. The youngest one was a period of one month. So it is easy to say to somebody else give me the money; but that money comes from taxation and by the time it comes back to us it is going to cost us a whole lot more. I think as the States assume their own responsibilities and carry on, it is going to be beneficial to all of us not only from the prospect of carrying our own program but also from the problem of paying taxes. I am allergic to taxes.

Question: My third question is: What can we do with the recalcitrant active case who has refused or resisted hospital admission in spite of adequate social service and psychiatric attention?

Answer: At the present time there isn't a great deal we can do. I mentioned the one law in Maryland, I think it is called Public Law 57. I know several years ago in one of the large, very large cities north of us, there was a Quarantine Law, quarantining patients with Tuberculosis to a City Contagious Disease Hospital. All that an individual who had Tuberculosis had to do to be admitted to a hospital—and many of them did want to—was to appear on the street and expectorate in the gutter or some place and have some friend of theirs lodge a complaint. By some court order they were quarantined and then they were eventually transferred into a Tuberculosis institution of that State. That City has been rather well taken care of at the sufferance of the rest of the State. We in Maryland do not have a sufficient number of beds, balanced, staffed etc., to have such a law on the books at the present time. Smallpox is almost extinct. There is only an occasional death from smallpox; there are many thousand deaths from Tuberculosis per smallpox death due to two things, vaccination plus compulsory isolation. It is going to depend entirely on the attitude of the public and the medical profession and the State Board of Health as to whether or not there will ever be recommended a law of compulsory hospitalization or isolation in this State which has any teeth in it. I personally believe that if such a law were on the books it would need to be used seldom because the person who carries a big stick and doesn't use it very often usually carries a great deal of authority.

Dr. Barnwell. I was curious about your statement on the waiting list. I don't know of any other area where there is so much discrimination made between sexes and bars of democracy as with Marylanders.

Dr. Hetherington: We cannot put them both on the same floor for some reason.

Judge Waxter: I have a question which reads:

Question: Why is the Baltimore City Hospitals under the Department of Public Welfare instead of the Health Department?

Answer: The reason I imagine is entirely historical. It seems the Baltimore City Hospital is the end result of an evolutionary development that began so far as we know in 1771, or 180 years ago, when they first established an Alms House for Baltimore Town; Baltimore City Hospitals is the great, great grandchild of that Alms House. Whether it should be with the Department of Welfare is quite a different thing. Municipal hospitals are set up in four different ways. In Cleveland the Health and Welfare Department is one Department under a single administrator. In New York they have a separate hospitals division of the City government. In Philadelphia they have their hospitals under the Welfare Department. In Washington they have their hospitals under the Health Department. The proof of the pudding is which of these hospitals represent the best institutions giving care to the patients, and having visited a number of the hospitals in the various cities throughout the country, you just can't come to any real conclusion. For instance in Maryland the State Tuberculosis Hospitals are under the State Health Department; the one Municipal institution of 450 beds at Baltimore City Hospitals is under the Welfare Department. Now you'd have to go in and make a study of those two systems to find out in which institution is the patient receiving the better care. Where is the level of care involved? Finally you have this situation: In the Baltimore City Hospitals, policy is determined by a Medical Advisory Board consisting of the Chiefs of the various services in the hospital; the Deans of the two Medical schools; the Director of Health, and the Director of Welfare which is where it should be. Where an institution should belong in any community depends upon where you can put it and get the highest standard of care for patients.

Dr. Barnwell: Thank you, Judge Waxter. These questions haven't turned out to be as difficult as I expected. I expect that is through the talent of the panel. Now, Miss Dooley.

Question: My question is, "Why do nurses generally refuse to accept a Tuberculosis case?"

Answer: Changed a little bit, Why do nurses generally refuse to accept an assignment in caring for patients with Tuberculosis, my answer is that Tuberculosis nursing is not part of the basic curriculum in Schools of Nursing, and nurses reluctantly go into an area of nursing where they feel inadequate. Dr. Langeluttig spoke at some length about teaching Tuberculosis in the Medical schools. Traditionally, nurses tie themselves to the progress that is made by the doctors, and I think that as the doctors begin to develop this program in their own training programs that it will be easy for the Nursing Schools to follow. The second thing is the nature of the disease and the treatment offered the patient has not been particularly attractive to nurses in the past. And the third is the location of the hospital is usually away from the centers of professional activity and from recreational facilities, and nurses are reluctant to isolate themselves from these activities.

Dr. Barnwell: Now, Judge Waxter pointed out some of these questions involved not only medical science but political, social science, and administrative skills. I think Dr. Robinson is willing to admit this question is absolutely relevant from the point of view of medical science and may hit on some of the others.

Dr. Robinson: The first question is:

Question: Would a single Tuberculosis control office for City and State make for greater efficiency, and if so how could this be accomplished?

Answer: I suppose I am asked that question because I'm unofficial. I should say categorically without giving any reasons that a single Tuberculosis Control office of the whole State would be more efficient in some ways. How to bring this about would be to fuse the Baltimore City Department of Health with the State Department of Health. I think the Baltimore City Health Department, historically is much older than the State Health Department and I don't think that there are situations in this country where there is more autonomy in a city in relation to the State as in Baltimore. The Baltimore City Health Department certainly if it is going to exist, must have a Department of Tuberculosis; whether the efficiency between the State and City can be increased is a matter of administration and cooperation. The Commissioner of Health in Baltimore City is on the State Board of Health and there seems to be a very definite cooperation and teamwork between the City and State, but it does create some difficulties in Administration. I don't think there is any way to accomplish a fusion unless it be very radical which is not going to happen. Now the other question.

Question: How many Social Service Rehabilitation workers are there working in the Baltimore area; how many are needed and what prospects are there of getting them?

Answer: Well, for the whole State, there are seven professional social workers in the field of Tuberculosis. I won't go into just the city because they are brought together. The social work in Maryland is headed by the social work consultant in Dr. Hetherington's Department, the Bureau of Tuberculosis, and there are four social workers doing hospital social work, three on his staff and one on the staff of the Maryland Tuberculosis Association. There is one social worker in one Baltimore clinic and there is a Social worker in the Tuberculosis Division of Montgomery County Health Department, so there are only seven in the whole State. We need one social worker for every one hundred patients, that is, we ought to have at the present time ten, at least in the State Hospital and about four or five in the City Hospital. There is a social worker in one of the private hospitals, I think in Mt. Pleasant and Eudowood is interested in having a Social Worker added. There is a great deal of interest and this whole matter is going ahead. Now, as for rehabilitation, there are two people on the Rehabilitation Staff who are concentrated on Tuberculosis. One covers the State Hospitals. She does practically nothing but Tuberculosis but gets a great deal of cooperation from all the other members of the Rehabilitation Staff of the State. The other one is the Rehabilitation worker in Baltimore City who spends a considerable part of her time working with the Tuberculosis patients in the City Hospital as that also is part of the State service, or State Vocational Rehabilitation Service of the Department of Education. All these things are, as I said, demonstrations and by no means are these services complete here or anywhere else unless it is at some of Dr. Barnwell's hospitals.

Question: (By Dr. Sauer:) My first question is: Is puberty still the most dangerous age for getting Tuberculosis?

Answer: I think this must be under the heading of "leading questions." It is not; if one interprets the getting of Tuberculosis as getting Tuberculous infection. Infancy I believe always has been the most hazardous period for survival following infection. The question may be answered in reverse. There are evidences that childhood, the period between say five and fourteen is probably the safest age at which to be infected. Although the age of death is shifting and has shifted in to older age groups quite rapidly particularly among males, still there probably isn't too much to choose, so far as the optimal age of infection is concerned.

QUESTION: My second question is: Last year there were 500 deaths and 1400 cases reported in Baltimore City, how many cases would you estimate are undiagnosed?

ANSWER: I'm afraid this is an unanswerable question. I'm quite sure for one thing, ratios that have been set up are generally not applicable. For instance if one tried to establish a ratio between mortality and disease, it might hold for "whites" and not for negroes in whom the problem is a different one for perhaps a number of reasons. There has been a belief, as you know, or an idea, a very ancient one, in that it arose at the time of the Framingham survey back around 1918. Perhaps I shouldn't describe that as ancient, but a view that there were perhaps nine or ten cases of tuberculosis in the community for each annual death. Now that is an attempt to relate an incidence of mortality, a rate of dying to a prevalence of disease. That survey was based on the crude methods then available. X-ray was not a part of it; surveys that have been done since seem to indicate that they weren't so far off the mark. As for relating the number of deaths to the number of new cases in a given year which is that of relating a rate to a rate, I don't believe it can be done, because you'd first have to define a case and decide when the individual became a case. That is almost an impossible definition. However, it has been true that the community surveys were a more effective case finding mechanism and active programs have had a higher ratio of new reported cases to deaths than one would expect. That is one sort of a measurement.

QUESTION: Is the incidence of tuberculosis higher among nurses working in general hospitals as compared to those working in a tuberculosis sanatorium?

ANSWER: Again, an answer is difficult because many student nurses enter the institutions uninfected. They definitely have a higher risk of tuberculosis than graduate nurses. Student nurses as a rule do not spend much of their time in Tuberculosis Sanatoria, they may affiliate there but that is all. There are a few sanatoria that maintain programs for student nurses, so that you have difficulty in comparing. However, my answer to that would be that in institutions where the teaching and the care for proper techniques are sound, that the risk is pretty small in either event. I think perhaps Miss Dooley would like to comment on that.

MISS DOOLEY: Well, the danger lies in working in facilities that are not adequate to carry out isolation techniques. It has been my experience that well run hospitals have had a relatively low incidence of tuberculosis. I'd like to ask the Moderator about the comparison of tuberculosis in Tuberculosis Hospitals, General hospitals and psychiatric?

DR. BARNWELL: If you want the Veterans Administration experience, we have very few student nurses. There are a few places where we do have affiliation programs but taking personnel as a whole, including the nurses, there is no difference in our several types of hospitals. They are divided into General hospitals, Neuropsychiatric hospitals and Tuberculosis hospitals and the incidence runs about one-tenth of one per cent; there is no difference in those hospitals. Mr. Weiss, your question?

MR. HARVEY WEISS: The question as described, is an ideal situation but the fact remains the General hospital places many barriers in the path of the patient with Tuberculosis who needs temporary hospitalization.

Question: Are the Superintendents of General hospitals locally facing up to this situation?

Answer: Well, the answer to that is no, they are not. I do want to say in their defense though, that temporary hospitalization in the eyes of a superintendent in the Tuberculosis hospital is rather a relative term when compared to temporary hospitalization in the general hospital. It is like the visit of a mother-in-law; I mean you never know how long they are going to stay. Temporary hospitalization might mean months, and if you take what Dr. Silverman and Dr. Hetherington said, it could mean a long time. Once people get into General hospitals and they have to go back home, the chances are that they either don't want to go home or they won't go into a special hospital. But, I'm sorry to say, General hospital superintendents in Baltimore area are not facing up to the situation. That's an honest answer to this question.

Dr. Barnwell: Now the question from Dr. Langeluttig.

Question: My first question is, how many hours are devoted to Tuberculosis in the local Medical Schools?

Answer: I can speak only for the University of Maryland Medical School and say that the Junior students receive between twelve and sixteen hours of didactic lectures devoted entirely to Tuberculosis. Now in addition, of course, they receive didactic lectures regarding other diseases of the chest and occupational diseases of the chest. However, there is very little if any practical work on Tuberculosis wards. City Hospital is not utilized except for the teaching of physical diagnosis.

Question: My second question is, do you practice what you preach as far as the program for early case finding among student nurses and house staff?

Answer: Again at the University of Maryland Medical School students and nurses are X-rayed and have tuberculin tests done on admission to the respective schools. If they are tuberculin negative they are followed by tuberculin tests at regular intervals, and of course if they should turn positive during their period of training they are then X-rayed and followed very carefully. Those students who come into the school with a positive tuberculin test are X-rayed at regular intervals. Now, the House Staff of the University and Mercy Hospitals are X-rayed. I can't speak of other hospitals from personal knowledge, except at City Hospital they also carry out that policy. In addition we have a policy of offering BCG vaccination to intern and staff nurses who are tuberculin negative. That is not compulsory in any sense of the word. We simply state to the individual what our knowledge is, what our feeling is about the matter and let them make their own decision.

Dr. Barnwell: Thank you, Dr. Langeluttig and now Dr. Sauer.

Question: Do you think it is possible to get the cooperation of the Press in avoiding premature dissemination of information about unconfirmed cures?

Dr. Sauer: I'm a great believer in freedom of the Press and I think the Press should not be restricted in terms of publication. Now, when is a cure going to be confirmed or unconfirmed? There are many things I read in the newspapers which I don't believe; sometimes I read one thing and on the next page I read something else and the next night I'll read something else and there must be a little fib in it somewhere because they can't all be telling the truth. Maybe some are telling a part of it and maybe all are telling none of it. I don't know. I think the Press does cooperate in a certain sense that the more vicious of these unconfirmed cures where a person is out for personal profit are not published. If you would look through some of the publishing in the paper of 1890 and what you will see in the paper today, you will realize that the Press has suppressed a goodly portion of the really vicious type of cures.

Now, if a person has a premature release in order that there is some financial gain to it, then I would say that something can be done through the A.M.A., as far as that doctor is concerned. However, I might feel that a project is half baked and not ready for publication at all; one of you might be working on the same thing and might say it is completely ready for publication. Who is to judge? If a man thinks that he should publish and that he has the necessary information, I would say let him go ahead and publish and let us do the judging. If he is publishing for gain, financial gain or something of that nature, then by all means I think we do have the power to at least censure him.

How often are doctors and drug firms at fault? Well, sometimes doctors are at fault and again I think I have stated what I think about doctors. Occasionally there will be two drug firms working on a product. The drug firm that publishes first, say they have a terrific advantage for the next twenty years. It is up to the other fellow to catch up to them. Occasionally a drug firm does publish something which probably is premature. I know of no law that we have to hold back the drug firm.

Dr. Barnwell: I want to thank the chairman for his splendid organization and sense of timing; thank the members of the Panel for their contribution and thank the Faculty for their patience.

HOURGLASS PERINEURAL FIBROBLASTOMA ON THE CERVICAL PART OF THE VERTEBRAL COLUMN[1]

JOSEPH M. MILLER, M.D.,[2] JAMES G. ARNOLD, M.D.,[3] AND JOHN T. BRACKIN, JR., M.D.[4]

In a recent excellent article, Love and Dodge (1) point out that neurofibromas are the most common tumor affecting the spinal axis and frequently assume an hourglass shape. Other tumors which may occasionally assume an hourglass shape are fibromas, ependymomas, lipomas, enchondromas, meningiomas, hemangio-endotheliomas, ganglioneuromas, sarcomas and carcinomas. Chordomas, blastomycosis, echinococcosis and the commoner granulomas may also produce an hourglass lesion. The opportunity to treat an hourglass neurofibroma of the cervical part of the vertebral column in a patient, who had previously incurred a gunshot wound of the homolateral extremity with neurological deficit, presented an interesting problem.

Case Report

A 32 year old white male was admitted complaining of a painless mass in the left neck of three weeks' duration. The tumor had been found on a routine physical examination for employment.

The patient received a gunshot wound of the right forearm in 1945. Healing had occurred with partial injury to the right median and radial nerves, and partial loss of the soft tissues. Limited supination, pronation and extension of the right wrist, limited flexion of the fingers of the right hand and limited abduction of the right hand were present. Progression of the neurologic deficit had not occurred since the injury in 1945.

A non-tender, slightly movable mass measuring about four by five by four cm. was present just above the medial portion of the right clavicle (figure 1). The mass was moderately well fixed to the underlying structures and did not pulsate.

Laboratory examinations were negative. Roentgenograms of the cervical spine demonstrated smoothly eroded intervertebral foramina of the right sixth and seventh

---

[1] Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the authors are the result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

[2] Chief, Department of Surgery, Veterans Administration, Fort Howard, Maryland.

[3] Consultant in Neurosurgery, Veterans Administration, Fort Howard, Maryland.

[4] Chief, Department of Radiology, Veterans Administration, Fort Howard, Maryland.

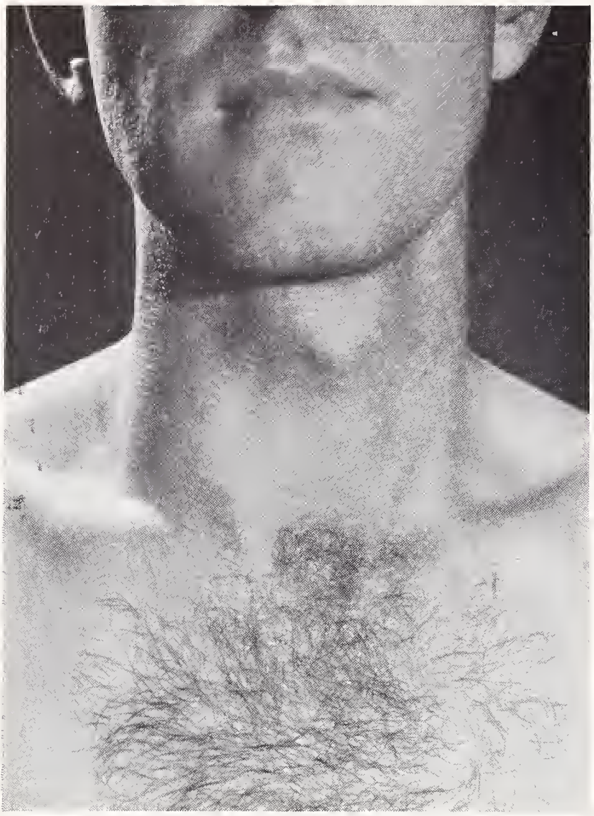


Fig. 1. Soft tissue mass in right lower cervical region.

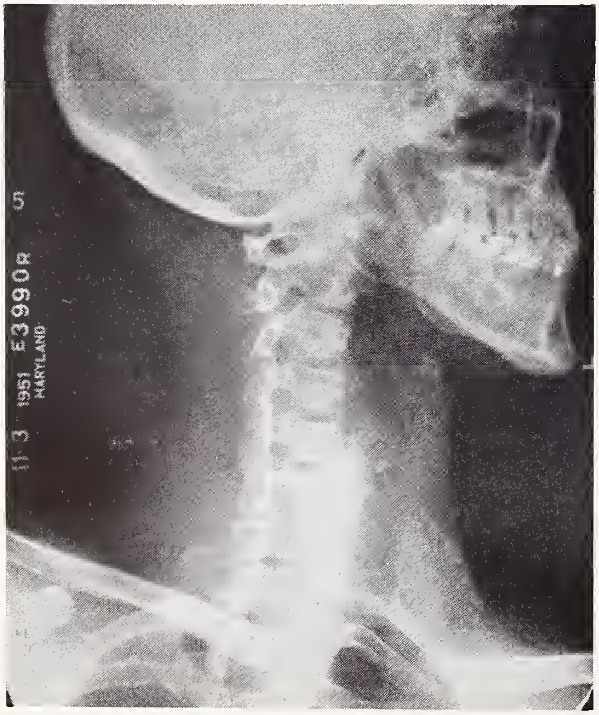


Fig. 2. Enlarged sixth and seventh intervertebral foramina.

cervical vertebrae (figure 2). Slight compression of the dura mater at the same level was demonstrated by the myelogram (figure 3) done with 12 cc. of pantopaque.

Subsequently, a two stage operation for removal of the tumor was done. At the first operation, a hemilaminectomy of the fifth, sixth and seventh cervical vertebrae was done. A completely encapsulated tumor was encountered and freed. The sixth and eighth cervical nerve roots were easily dissected free but the seventh was freed with difficulty and a portion of the capsule of the tumor was left. The distal portion of the seventh nerve root traversed the capsular portion of the tumor. The neoplasm was opened and curetted to decompress the mass. The tumor was not adherent to the dura mater but there was close apposition of the tumor to its lateral side.

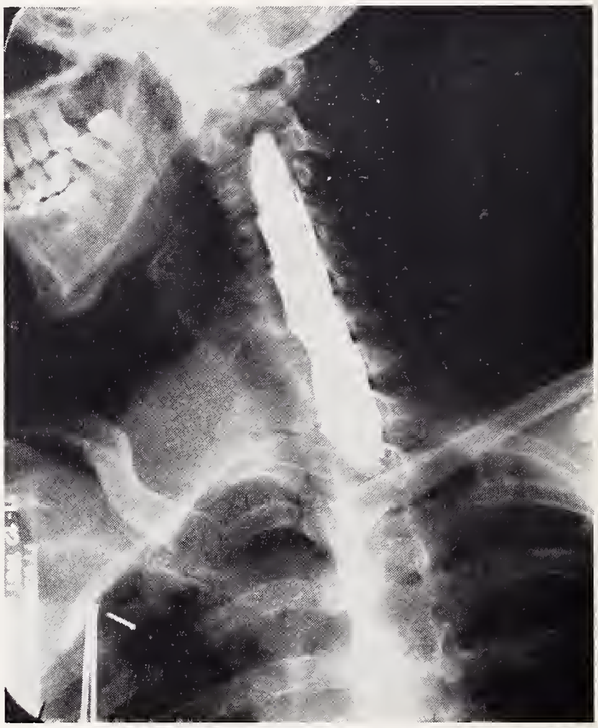


Fig. 3. Myelogram done with 12 cc. of pantopaque showing a smooth concave defect, and absence of filling of nerve cuff at the level of seventh cervical root.

Four days later an incision was made along the posterior border of the right sternocleidomastoid muscle. The muscle and the carotid bundle were retracted medially. The thin atrophic anterior scalene muscle overlying the tumor was divided. The phrenic nerve was retracted laterally. The mass was freed entirely and the seventh nerve root was left intact. A portion of the capsule was left on the nerve. Faradic stimulation of the nerve showed the conductivity to be intact and further dissection of the root was not done. A Penrose drain was inserted. A spinal fluid fistula from the posterior wound was noted in the postoperative period. This was controlled by removal of spinal fluid and aspiration of a collection of fluid at the site of the wound. Microscopic examination, by Jack M. Burnett, M.D., showed a loose network of connective tissue fibres in which there were elongated cells with typical nuclei. In some areas, palisades of elongated nuclei were seen. A diagnosis of a perineural fibroblastoma was made.

COMMENT

Because of the location of the tumor in the anterior part of the neck, the nature of the neoplasm was not suspected until roentgenograms of the cervical portion of the vertebral column were taken. The right median and radial nerve damage had not shown progression since the original injury and therefore, the tumor was not related to the neurologic deficit. How long the tumor was present is unknown.

The tumor can be classified in the third group of Love and Dodge as extradural and extraspinal. Of 60 hourglass neurofibromas reviewed by these authors, 26 were located in the cervical portion of the vertebral column. In these cases, the only symptoms were referable to root involvement. The patients usually noticed pain or numbness in the arm, hand or fingers. Signs of cord compression occurred frequently.

SUMMARY

A large hourglass perineural fibroblastoma was successfully removed in a patient with a painless tumor in the posterior triangle of the right side of the neck just above the clavicle. The diagnosis was suspected after the oblique roentgenograms showed bony erosion of the laminae of the sixth and seventh cervical vertebrae. Myelography demonstrated the mild compression of the dura mater.

REFERENCE

1. LOVE, J. G. AND DODGE, JR., H. W., Dumbbell (Hourglass) Neurofibroma affecting the spinal cord. Surg., Gynec. and Obst. **94:** 161–172 (Feb.) 1952.

PSYCHOSOMATIC MEDICINE IN GENERAL PRACTICE

E. PAUL KNOTTS, M.D.*

We are living in a fabulous age. The frontiers of medical practice have been conquered to an extent undreamed of by those of a generation ago. Diagnosis, of even obscure conditions, is often made easy by simple tests and treatment with resultant lives saved, disabilities removed and health and happiness substituted for death. Of equal importance, preventive medicine has all but conquered pestilences and plagues that, in the past, have changed the way of life of nations and have caused great nations to crumple and die. One of the wonders of our age is the speed with which new methods of diagnosis and treatment are adopted in the office of the most remote General Practitioner. This is one of the outstanding triumphs of organized medicine.

One field of medicine as ancient as man, preceding, in primitive forms, the written word, is now dignified by the mouth filling connotation, "psycho-somatic medicine." It represents a frontier that has not been pushed back and by comparison with the epochal victories over the Captains of the Men of Death, constitutes a reproach to our profession.

Perhaps this is true only because this field of medicine needs a new approach. It is my considered opinion that the great group of men and women who have dedicated their lives to the relief of pain and the curing of disease have the patience and the inclination to take over any task that means the alleviation of human frailties. Happiness is only achieved in service and the medical men can secure happiness in direct proportion with this concept. It is true that the diagnosis and prompt cure of pneumonia, typhoid fever and meningitis represents soul satisfying accomplishments, yet the quieting of a

---

* Denton, Md.

tempestuous household, the restoration of an alcoholic to sobriety, the saving of a potential suicide represents service that can be as dramatic as somatic victory.

The tremendous scope that psycho-somatic medicine includes might be indicated by mentioning a few of the conditions to be met. Alcoholism, colitis, fatigue states, allergies, lost libido, migraine, epileptic equivalents, tachycardias, and when the storm is severe, auricular fibrillation. Also chronic dyspeptics and even peptic ulcer, pruritis ani, and dermatitis. In no phase of medical practice does one escape the difficult differential problems presented by the psychoneurotic patient.

Paulson has said: "Only that which is obscure arouses passion, for evidence excludes individual choice." Inner unrest has been compared to pain. A toothache, at least, informs the victim of the source of his trouble. Pain is not the only sensation hard to bear. Everyone has known the sensation of fear, of apprehensions, of intolerable suspense in relation to personal situations. Some times such feelings are experienced without any realization of their origin. If anxiety is sustained and its source is not traced, the person experiences, not only distress, but the helplessness that comes from dealing with unknown rather than a known danger, frustration or pain.

The civilized person is presented with a world that has many savage implications, and yet so filled with taboos, personal, social, intellectual and spiritual, that conflicts can take place at such deep levels that he scarcely knows they exist. The effect of such conflict is obvious. There is anxiety, with its source mystifying to the patient and doctor alike. "Sorrow which has no vent in tears may make other organs weep." (Maudsley). If his symptoms had had behind them positive serology evidences of cerebral vascular accident, thyroid disease or some eye ground evidence of cerebral arteriosclerosis then the diagnosis would have been easy. When there is no pathology to be found even the symptoms may be missed because the inquiry did not elicit them. The study had been of the disease and not of the man who had the disease. The patient is dismissed with a prescription for phenobarbital, a pat on the back and goes on down the street to the chiropractor. Potential or mild psychoneurosis has now been aggravated and perhaps has become a fixed pattern.

Worse, might have been the finding by X-ray of a gall bladder which filled poorly with dye; a retroverted uterus; ptosis of some abdominal viscera; or in a much scarred abdomen have made the diagnosis of intestinal adhesions, lampooned by Osler as "the refuge of the diagnostically destitute" and referred the sick creature to a specialist for further surgery. One must remember that no disease of the abdominal organs can produce a psychoneurosis. That must arise in the brain.

The problem presented by psycho-somatic medicine cannot be delegated to specialists. There are not enough psychiatrists in the world and there never will be, to care for all the misplaced; constitutional inadequate personalities and the marginal psychotics. It is the responsibility of the general practitioner to be able to recognize incipient insanity and to secure consultation before the psychosis becomes a fixed pattern and so resistant to treatment that nothing remains but permanent commitment for custodial care.

Frequently the diagnosis of insanity can be made easily. Sudden changes in habits and personality traits; memory and insight failures; temper tantrums; phobias; depressive and euphoric characteristics; inability to concentrate; impaired judgment; moral degeneracy. The patient frequently may have some knowledge of his basic changes and in the presence of the doctor may be able to conceal his abnormal trends. Parents, children, neighbors and business associates may be invaluable in arriving at a diagnosis. Knowledge of siblings and family background which may contain numerous cases of the constitutionally inadequate or even the insane may make it easier to understand and to adjudicate personality changes in the patient.

The treatment of psychosomatic states is akin to all afflictions of mankind. First is diagnosis. Realization that there is a lack of something in the brain that keeps most people well and unconcerned about health is important. Perhaps the brain is being used uneconomically with foolish worrying, silly thinking, conscience searching, jealousies, conflicts with people and riots of emotion. One must try to get these people to use their brains more gently in seeking happiness on less strenuous levels; to evoke basic changes in the patient's attitude; release anxieties, hostility and resentments; to reduce the pressures on the patient by getting the family, marital mate and others to understand the situation and to stop blaming the patient for inadequacies and failures.

The doctor must assist the patient to break monotonies, dissipation, overwork and to find consolation for sorrow and misfortune. The Priest, the Rabbi, and the Rector are willing and often able assistants. Some times, treatment must be by diverting the psychic directions, to become an extrovert by the medium of club work, church activities, delving into the arts as music, painting—or vocational pursuits such as carpentry, flower culture, masonry. Sometimes mental and emotional health can be brought under control only by removing such activities and prescribing rest periods and vacations.

In conclusion, the physician must successfully analyze the source of fatigue, neurasthenic and hypochondrical states, anxiety, resentments, self depreciation and frustrations, and institute treatment that will prevent the establishment of a fixed and permanent pattern of reaction to environment.

Great care must be exercised in discussing a diagnosis of organic disorders with the patient lest a potential psychoneurotic be spilled over into that unhappy state.

The recognition of incipient insanity and the prompt reference of such patients to a psychiatrist may result in preventing the deterioration of the patient into more grave psychoses.

Recognition and treatment of the bulk of the psychoneurotic states must remain the responsibility of the general practitioner.

* * * * * *

NEED AT ABERDEEN PROVING GROUND FOR A MEDICAL OFFICER AND FOR AN INDUSTRIAL SURGEON

At present there is an urgent need at Aberdeen Proving Ground for a Medical Officer and for an Industrial Surgeon. The salary of the Medical Officer (General) ranges from $7040 per annum to $8040 per annum and the salary for the Industrial Surgeon ranges from $8360 per annum to $9360 per annum.

Aberdeen Proving Ground is a permanent Army Post located in the Susquehanna River valley where this river meets the Chesapeake Bay. It is four miles off modern highway Route 40 midway between Baltimore, Maryland, and Wilmington, Delaware.

The Proving Ground has a beautiful, new-well-appointed ten room dispensary, staffed with two registered nurses, a clerk and a receptionist. The variety of jobs and the great diversity of mission at Aberdeen gives the progressive Industrial Surgeon a challenge that is both interesting and exciting.

For information write to Virginia P. Kirk, Employee Utilization Representative, Civilian Personnel Division, Headquarters Building, Aberdeen Proving Ground, Maryland, or telephone Aberdeen 1000, Extension 3113.

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

The Allegany-Garrett County Medical Society held its meeting on Friday, December 19th at Memorial Hospital.

Dr. Ernest J. Fogel presented a paper entitled "Electroencephalograms and Their Contribution to Medical Diagnosis." Dr. Fogel is Chief of Neurology and Psychiatry at the Veterans Hospital in Martinsburg, West Virginia.

At this meeting, Dr. Samuel Jacobson presented a patient who has recently had a successful operation for mitral stenosis and had a satisfactory recovery.

Dr. Benedict Skitarelic, Cumberland, gave a lecture on "Hematology" and "Venipuncture, Infusions and Hypodermoclysis" at the Civil Defense nurses training program session held recently in Cumberland. This was the second in a series of lectures, the first being "The Role of the Nurse in Mass Handling of Casualties in Time of Disaster" delivered by Dr. A. J. Mirkin.

Dr. L. R. Meyers, Cumberland, is in Florida vacationing at his orange grove near Fort Lauderdale, for two months.

DR. CHARLES L. OWENS

Dr. Charles L. Owens, 305 Washington Street, Cumberland, now retired, was happily surprised by some of his close physician friends of many years. Some whom he had been closely associated with, but many whom he had been the family adviser for their families. Charlie had delivered their babies and cared for their wives, sisters and children these many years and did it well. At Christmas, they brought with them a lovely Television set, for Charlie to use and while away the time when he isn't writing his memoirs for posterity.

Dr. Owens was always the kindhearted kind of the old school, a delightful bedside manner and a true friend. His smile has never left his face, even though he has been confined to his room these past years. Never losing his interest in medicine and loves to talk it over to the steady trek of his professional friends, who never miss a day in dropping in to chat. He graduated at Maryland University in 1904 and has been happily married for 45 years to the former Betty Ann Edwards.

Dr. Owens would love to have his old classmates write or drop in on him sometime.

DR. GEORGE MURRAY SIMONS

Dr. George Murray Simons, LaVale, is the first Cumberland area physician to receive orders for induction into the armed forces under Selective Service regulations.

P. Emmett Fahey, clerk coordinator of draft boards here, said Dr. Simons will report December 30 in Baltimore for military duty.

Following a pre-induction physical examination some time ago, Dr. Simons was placed in Priority 2—medical men educated at government expense and with less than 20 months of active service.

During World War II, Fahey said, doctors and dentists entered service under a procurement system not covered by Selective Service Laws.

Born in Rainsburg, Pa., Dr. Simons came here with his parents at the age of one month. He attended public schools and was graduated from Pennsylvania Avenue High School. He entered the Army soon after graduating from the University of Maryland School of Medicine in September, 1944.

Dr. Simons served in the transport command on the Pacific Coast for about two years and was discharged with the rank of captain. He completed his internship at University Hospital, Baltimore, and also was assistant resident physician there.

Later Dr. Simons returned to Cumberland and served as resident physician at Memorial Hospital for six months, resigning August 1, 1948 to begin his private practice here.

Dr. Leon A. Kochman, a native of Cumberland, now practicing in Baltimore, conducted an arthritis clinic here Friday, December 5, through the auspices of the Allegany-Garrett County Medical Society. Dr. Kochman was at the Allegany County League for Crippled Children's Building from 9 a.m., until noon, and was available for private consultation at Memorial Hospital by appointment, from 1 until 5 p.m.

Recently Dr. W. Royce Hodges, spoke to the Allegany-Garrett County Medical Society and reported 5,000 obstetric cases with an analysis of the different methods of anesthesia used. Twenty one hundred were given continuous caudal analgesia. Four hundred received continuous spinal anesthesia and saddle block, while the rest were managed by the so called natural childbirth and the usual anesthetics.

The cases dated over a period of the past ten years, 1942 to 1952.

Baltimore City Medical Society and its Sections
Meetings will be held at 1211 Cathedral Street unless otherwise stated

---

BALTIMORE CITY MEDICAL SOCIETY

Wetherbee Fort, M.D., *President*
Lewis P. Gundry, M.D., *Vice-President*
Edward F. Cotter, M.D., *Secretary*
Robert C. Kimberly, M.D., *Treasurer*

Friday, March 20, 1953, 8:30 p.m.

SEMINAR: RECENT ADVANCES IN RADIOLOGICAL STUDIES OF THE VASCULAR SYSTEM

Charles T. Dotter, M.D., *Moderator*, Professor and Chairman, Department of Radiology, University of Oregon Medical School, Portland, Oregon.

Participants

Pulmonary Angiocardiography. Israel Steinberg, M.D., New York City.
Peripheral Angiography. E. Converse Peirce, II, M.D.
Cerebral Angiography. John W. Chambers, M.D.
Angiocardiography. Charles T. Dotter, M.D., *Moderator.*

OPHTHALMOLOGICAL SECTION

Angus L. MacLean, M.D., *Chairman*
Harold C. Dix, M.D., *Secretary*

Thursday, March 5, 1953

Cocktails 6:15 p.m. Dinner 7:00 p.m.

Glaucoma. Paul Austin Chandler, M.D., Boston, Massachusetts.

CANCER SECTION

Edward F. Lewison, M.D., *Chairman*
Robert N. Cooley, M.D., *Secretary*

Wednesday, March 11, 1953, 8:00 p.m.

The National Institute of Health, Bethesda, Maryland

Dr. John R. Heller, of the National Institute of Health, is arranging this meeting. The program and exact meeting room will be announced later.

A cordial invitation is extended to *All* members of the Medical and Chirurgical Faculty.

CANCER SECTION

ROBERT N. COOLEY, M.D., *Secretary*

The first meeting of the Cancer Section of the Baltimore City Medical Society for the current academic year was held at the National Cancer Institute on Friday evening, October 3rd. Dr. J. R. Heller, Director of the National Cancer Institute of the National Institutes of Health, was responsible for arranging the program and the members of the section are indebted to him and his colleagues for an interesting and instructive meeting.

Most of the Baltimore group did not arrive on the grounds of the National Institute of Health in time to obtain a daylight view of the New Clinical Center Hospital. However, it is a massive and impressive structure of fourteen floors and is now nearing completion. It is expected to start receiving patients on April 1, 1953.

Dr. Heller, the first speaker on the program, described many of the extensive facilities which will be found within the new hospital. Primary attention will be given to those diseases which are now the major cause of mortality and chronic ill health among the American people and emphasis will be placed on basic research; therefore, a predominantly large area of the hospital will be given to laboratory space. A basic laboratory unit or module has been designed which it is believed will be very flexible in operation. It consists of an area 12 × 20 feet in dimension in which partitions can be arranged to suit the needs of the particular investigation which is to be carried out. These modules are in close physical relation to the patient area and are almost autonomous in their operation. The hospital will ultimately contain approximately one thousand such units.

In addition to the extensive laboratory facilities, there is ample space devoted to the clinical examination, care and treatment of patients. The standard nursing unit is designed to take care of twenty-six patients. These twenty-six patients will be housed in two bed wards, each of which has an adjacent toilet and bath. All rooms are air-conditioned and are outside rooms. Much attention has been given to such details, as easily maneuverable beds; hand rails for ambulatory patients are present throughout all the corridors; door widths are ample and such items as a new model bedside lamp have received attention. Indeed, it is impossible in a short space to outline all the developments and facilities which the hospital contains. Needless to say, it will provide the most advanced type of hospital facilities now known.

The total capacity of the hospital under normal conditions is expected to be five hundred patients. Of these, one hundred and twenty-five beds will be devoted to cancer research and one hundred beds to research of diseases of the heart. An interesting feature is that the capacity of the hospital can be expanded under emergency conditions to receive upwards of three thousand patients. The hospital could therefore be quite useful in case of a catastrophe or local emergency. Patients will be accepted only upon reference from their attending physicians. The sole criterion for acceptance or admission is that the patient be suffering from one of the conditions under investigation in the center at that particular time.

A second paper of the scientific program was presented by Dr. Harold P. Morris on "The Experimental Production of Malignant Thyroid Tumors by the Administration of Thiouracil."

Thiouracil when administered to mice depresses the activity of the thyroid and brings about a compensatory increase in secretion of the thyro-tropic hormone of the pituitary. The thyroids of a certain strain of mice (C 3 H.) under such treatment showed enlargement, and thyroid metastases were found in the lungs. If a portion of the thyroid or of a lung metastasis in these animals is transplanted subcutaneously to mice of the same strain who are also under the effects of Thiouracil, these transplants will continue to grow. After four transplants in one instance, a lung nodule developed which after the seventh transplant became completely autonomous and was able to grow in the tissues of normal mice. A second series of transplants from the thyroid of another animal produced in the ninth generation a tumor line which grew autonomously in normal mice, but which grew much more rapidly in mice fed on Thiouracil. Histological studies in both series of transplants revealed a gradual transition of the normal thyroid into an adenomatous type of tissue with some evidence of malignancy. Apparently two different tumor strains were produced. The differences in these strains consisted in: 1) histological structures; 2) size; and 3) ability to assimilate Iodine 131. There was thought to be considerable correlation between the histological appearance and the degree of malignancy of the tumors.

A third paper on "The Production of Carcinoma of the Cervix Uteri in the Experimental Animal," was presented by Dr. Edwin Murphy.

Carcinoma of the cervix is rarely seen in animals. In 1938, Allen reported an unmistakable cervical cancer in a mouse, produced by the prolonged use of estrogen. Also, a strain of mice which in England were highly susceptible to osteogenic carcinoma, upon being removed to New Haven, Connecticut, began to develop carcinoma of the cervix with frequency. However, this same strain when housed at the National Cancer Institute did not produce carcinoma of the cervix.

Because of this failure to produce carcinoma in the experimental animal with regularity, Dr. Murphy explored the possibilities of producing the tumor by exogenous or extrinsic factors such as the local application of an acetone solution of methyl-cholanthrene directly to the cervix of mice. Dr. Murphy modified an otoscope for use as a vaginal speculum and, no doubt, he became quite proficient in applying his carcinogenic agent directly to the cervix. After a latent period of about nine months, approximately one-third of the exposed animals developed a carcinoma of the cervix. Later, about 50 per cent of the exposed animals could be made to develop a carcinoma which was similar in most respects to the disease as it occurs in humans. Histologically, the tumors are squamous cell carcinomata somewhat more cornifying than the average human cervical cancer. These tumors invade the pelvic structures, particularly the rectum and bladder, producing blockage of the ureters, resembling in considerable detail the human disease. Pulmonary metastasis has been demonstrated microscopically, but lymph node metastasis has not.

The availability of numbers of experimental animals with cancer of the cervix has opened up new fields of study. Dr. Murphy has found that Papanicolaou examination of the vaginal secretions shows evidence of malignant cells about one month before any grossly detectable tumor appears. Furthermore, when the cancer is well developed abundant desquamated cells appear in the secretions. Several carcinomata in situ like lesions have been observed. Many other aspects of both development and treatment of the disease are now susceptible to investigation in the experimental animal.

Following the reading of the papers there was a short social hour with refreshments.

RADIOLOGICAL SECTION

H. LEONARD WARRES, M.D., *Secretary*

At the last meeting of the Radiological Section of the Baltimore City Medical Society, Dr. William Harris, Chief of Radiotherapy at Mt. Sinai Hospital, New York City, delivered a highly stimulating and provocative paper on "Carcinoma of the Larynx and Laryngopharynx."

At his institution, X-ray therapy is the treatment of choice for the above-mentioned malignancies, and they have now treated 139 patients from 1931 to 1947, inclusive. Their absolute five-year cure rate was 48%, and their absolute ten-year cure rate was 41%. These results were comparable to those obtained elsewhere with surgery; however, utilizing radiotherapy, the larynx was maintained intact.

The discussants were Dr. Edwin N. Broyles, Associate Professor of Otolaryngology at The Johns Hopkins Hospital, and Dr. Grant E. Ward.

BALTIMORE COUNTY MEDICAL SOCIETY

DONALD L. SOMERVILLE, M.D.

Journal Representative

A recent meeting of the Baltimore County Medical Association was held at the Stafford Hotel. This was a joint meeting with the Woman's Auxiliary, and thus was of course one of the more pleasant meetings of the year. The guest speaker was Dr. Henry J. Marriott, Assistant Professor of Medicine at the University of Maryland School of Medicine. His interesting talk centered about the subject of Recent Milestones in Medicine, and pointed out the fact that there are three main mechanisms responsible for medical discoveries, so to speak: Flukes, Ingenuity, and Plodding. Examples of the first of these include the eventual development of Dicumarol from the investigation of cattle deaths 25 years ago, a story now familiar to all, and Fleming's wind-borne discovery of Penicillin. Dr. Marriott felt ingenuity was responsible for such milestones as Dr. Taussig and Dr. Blalock's collaboration on cardiac surgery, the eventual use of British Anti-Lewisite for a purpose foreign to its original development, and so forth. Plodding had led to the discovery, and is now leading to more discoveries, of antibiotics from the common soil; Dr. Marriott reminded us that the Bible pointed out the way in this last endeavor, quoting from Ecclesiastes: "The Lord hath created medicines out of the earth." Many important milestones in medical progress were touched upon, such as B_{12}, ACTH and Cortisone, the Rh factor and blood factors generally, antimalarial drugs, and the interesting change in attitude toward and treatment of Leprosy. Finally, some of the undesirable "by-products" of great discoveries were indicated, such as those arising from over-enthusiastic use of antibiotics: Sensitizations, interference with immunity, bacterial resistance and dependence, superinfections, and antibiotic antagonism.

A brief business meeting concerned itself primarily with the announcement by the Nominating Committee of the choices they had decided upon for next year's officers: President, Charles F. O'Donnell; Vice-President, Martin E. Strobel; Secretary-Treasurer, Thomas E. Wheeler. The delegates nominated are the same as the current year, Drs. David H. Andrew, James G. Howell, and Melvin E. Davis. Dr. Paul Royse spoke in behalf of the Medical Education Committee regarding the need for contributions to the American National Education Foundation, and it was moved that the Society as a whole contribute $100.00. Dr. Royse reminded the members that every dollar contributed is matched in effect 2 to 1 by the Foundation itself.

CARROLL COUNTY MEDICAL SOCIETY

WILBUR H. FOARD, M.D.

Journal Representative

The Carroll County Medical Society met at Hoffman Inn in Westminster, and after dinner Dr. Newland E. Day, of Baltimore, representing the National Foundation for Medical Education, made a special plea for the support of medical schools through this foundation. He went on to say that if we didn't support such a program we may have more Federal control of our Medical Schools.

Mr. Walter Kirkman, from the Medical and Chirurgical Faculty, advised us concerning legislative matters that may come up and urged us to cooperate and support the State Medical Society, as they endeavor to look out for our best interests.

Our guest speaker was Dr. John Wagner, from the University of Maryland School of Medicine, Department of Neuropathology. He gave a very interesting and informative talk on the neuropathological aspects of many diseases. Dr. Wagner illustrated his talks by showing many slides from cases from the University.

Carroll County's new $122,000 Medical Center, a memorial to the County's veterans of both wars, was dedicated at Westminster, Armistice Day.

The new Medical facilities have been planned both functionally and architecturally as the first unit of a future hospital for the County.

Governor McKeldin, who attended the ceremonies with Mrs. McKeldin, gave the principal dedication address.

Funds for construction of the center were donated by citizens of the County during 1943 and 1951. Additional funds were received from the Federal and State governments and the Commissioners supplied $7000 and will take over maintenance and care of the new building.

It was announced that a fund is now being accumulated by the County Commissioners that will, together with Federal aid, provide a minimum of $300,000 for hospital construction within the next few years. It was estimated that the building which was dedicated today will save $75,000 to $100,000 in the construction of a hospital.

Dr. Neal Gordon, County Health Officer, and his staff conducted the visitors, including the Governor and his wife, through the spacious, well lighted clinic and health offices.

Beneath the bronze plaque in the Memorial lobby, a bronze covered log has been installed bearing the names of those Carroll Countians who served in both wars.

Furnishings for the lobby have been donated by a Westminster Service Club.

HARFORD COUNTY MEDICAL SOCIETY

CHARLES R. HAYMAN, M.D., *Secretary*

The following are the minutes of the Harford County Medical Society, held on December 21, 1952.

Members present: Doctors Barthel, Hayman, Hudson, McDonald, Norment, Phillips, Rodman, Sandecki and Stansbury.

Old Business: 1. *Routine X-ray for patients entering Harford Memorial Hospital.* The committee presented this request to the hospital board, with an offer from the Tuberculosis Association to pay for X-rays of indigent patients. The board rejected the proposal.

2. *Chest X-ray for prenatal patients.* In view of the above decision, the Society voted that private patients (with low incomes) may be referred to the Health Department for this service. The doctor is to set the fee—from $2.00 to $5.00, depending on the income.

New Business: 1. *Maryland Heart Association.* In the majority of opinions a heart clinic is not needed locally. However, the association is to be asked to provide for indigent and medically indigent patients: transportation to Baltimore clinics; payment to Harford Memorial or County Health Department for EKG's, cardiac X-rays, sedimentation rates, etc.

2. *Medical and Chirurgical Faculty.* The following resolution was made by Dr. Phillips, seconded by Dr. Rodman, and unanimously passed: "That the Medical and Chirurgical Faculty be asked, when appointing committee members from Harford, to clear such appointments through the county society with approval of the county president."

3. *Election of officers for 1953.* President—Robert A. Barthel, Jr.; Vice President—Dudley Phillips; Secretary-Treasurer—Charles R. Hayman; Alternate Delegate—Richard C. Norment, 3rd; Delegate—Peter P. Rodman.

* * * * * *

THE DR. JACK W. KOLSON MEMORIAL LECTURE

sponsored by the House Staff of Sinai
Hospital of Baltimore, Inc.

Speaker: Dr. George W. Thorn
Professor of Medicine
Harvard University School of Medicine

STUDIES OF THE ADRENAL CORTEX

Friday evening, April 17th, 1953, 8:30 P.M.
Hurd Hall, Johns Hopkins Hospital

* * * * * *

ANNOUNCEMENT OF CONSULTANT TO THE EDITORIAL DEPARTMENT OF THE WILLIAMS & WILKINS COMPANY

It is announced by The Williams & Wilkins Company, medical publishers of Baltimore, Maryland, that effective with January 1953 Dr. Henry J. L. Marriott will become consultant to their editorial department.

Dr. Marriott is Assistant Professor of Medicine at the University of Maryland School of Medicine and is the author of a recent popular book, published by The Williams & Wilkins Company, entitled, "Medical Milestones."

* * * * * *

BOOKLET AVAILABLE—"ACCIDENT AND HEALTH COVERAGE IN THE UNITED STATES"

The Health Insurance Council annually publishes a booklet, "Accident And Health Coverage In The United States," which contains the results of the survey conducted on the subject. This booklet contains valuable information, and if you wish to order copies, it is suggested that you write to Richard J. Eales, Health Insurance Council, 488 Madison Avenue, New York 22, New York.

Library

NEW APPOINTMENT

We welcome to the Library Staff Mrs. Henry Berge, a graduate of the State Normal School at Towson, and of the Enoch Pratt Free Library Training Class. She has had a number of years experience in professional library work at the Pratt Library, in the public schools, and at the Park School, and comes to us well recommended.

With Mrs. Berge and Mrs Eleanor Kohler, who has been here several years, as assistants to Miss Wheeler, the Library should be able to continue its tradition of good service.

A SELECTED LIST OF PUBLICATIONS RECENTLY ADDED TO THE LIBRARY

Adler, Francis H., Physiology of the eye. 1951.

American College of Surgeons, Surgical forum. 1952.

Armour Laboratories, Physiological basis for the action of ACTH in human beings. 1951.

Army Medical Library catalog, 1950 & 1951.

Bachman, George W., Health resources in the United States. 1952.

Baer, Karl A. (compiler), Plasma substitutes. An annotated bibliography. 1951.

Beaumont, G. E., Recent advances in medicine. 1952.

Bland, John H., The clinical use of fluid and electrolyte. 1952.

Charnley, John, Closed treatment of common fractures. 1950.

Chew, Samuel C., Addresses on several occasions. 1906.

Cobb, Stanley, Foundations of neuropsychiatry. 1952.

Collins, D. H., Pathology of articular and spinal diseases. 1949.

Conn, Howard F. (ed.), Current therapy. 1952.

Duke University Bulletin. The first twenty years. A history of the Duke University Schools of Medicine, nursing and health services, and Duke Hospital, 1930–1950. 1952.

Elgood, Cyril, Medical history of Persia and the Eastern Caliphate. Cambridge, 1951.

Eller, Joseph J., Tumors of the skin. 1951.

Hayden Chemical Corporation. Neomycin. 1952.

Herbut, P. A., Urological pathology. 1952. 2 vols.

Howard, Marion E. (ed.), Modern drug encyclopedia and therapeutic index. 1952.

Institute for Research in Biography, Who's important in medicine. 1952.

Jordan, Edwin P. & Shepard, W. C., ℞ for medical writing. 1952.

Joslin, Elliott P., Treatment of diabetes mellitus. 9 ed., 1952.

Lederle Laboratories, Fifth year of aureomycin. 1952.

Longcope, W. T., Study of sarcoidosis. 1952.

Macalpine, J. B., Cystoscopy and urography. 1949.

Macht, David I., The holy incense. 1928.

Martin, Gustav J., Biological antagonism. 1951.

The medical directory, London, 1952. 2 vols.

Meyer, Adolf, Collected papers, vol. 4.

Meyer, Oscar D., That degenerate spirochete. 1952.

Newton, Sir Isaac, A descriptive catalogue of the work of Sir Isaac Newton. 1950.

Novak, Emil, Gynecologic and obstetric pathology. 3d ed. 1952.

Novak, Emil, Textbook of gynecology. 4th ed. 1952.

Plunkett, Richard J. & Hayden, A. C., Standard nomenclature of diseases and operations. 1952.

Quarterly cumulative index medicus, vol. 48, July–Dec., 1950, vol. 49, Jan.–June, 1951.

Rivers, Thomas N., Viral and rickettsial infections of man. 1952.

Smith, John, The pourtract of old age. London, 1676.

Soffer, Louis J., Diseases of the endocrine glands. 1951.

Stones, Hubert H., Oral and dental diseases. 1948.

Storch, Charles B., Fundamentals of clinical fluoroscopy. 1951.

Talbot, Nathan B., Functional endocrinology. 1952.

U. S. Federal Security Agency, Statistical studies of heart diseases. 1948.

Warren, Shields, Pathology of diabetes mellitus. 1952.

Watson, J. R., Hearing test and hearing instruments. 1949.

Williams, Ralph C., The United States Public Health Service, 1798–1950. Washington, 1951.

Winslow, C.-E. A., The cost of sickness and the price of health. 1951.

1951 Year book of drug therapy.

1952 Year book of general surgery.

1951 Year book of neurology and psychiatry.

1952 Year book of radiology.

Health Department

BALTIMORE CITY HEALTH DEPARTMENT

REPORTING OF OCCUPATIONAL DISEASES

At the request of the Dermatological Section of the Baltimore City Medical Society, Dr. R. R. Sayers, Senior Medical Supervisor for Occupational Diseases of the City Health Department staff, met with members of the group recently to discuss the revised occupational disease law. Particular attention was called to the fact that the law now covers all occupational diseases and not just the thirty-nine illnesses previously specified in the schedule.

This change was also emphasized in the report of the Committee on Industrial Health of the Medical and Chirurgical Faculty of Maryland, Nathan B. Herman, M.D., Chairman, from which the following is quoted:

> "Most, if not all, occupational diseases are preventable through the cooperation of the physicians, industries and the health department. Recognizing this requires the physician attending or called in to treat a patient whom he believes to be suffering from an ailment or disease contracted as a result of the nature of employment to report the case to the State Health Department, or to the Baltimore City Health Department. The post card used for reporting communicable diseases is also used for reporting occupational diseases."

Members of the Dermatological Section requested they be supplied with the cards on which these reports can be made and the City Health Department is complying with this request.

The above procedures apply not only to occupational dermatoses but to all other occupational diseases equally. These diseases can be prevented through the cooperative effort of the physician treating cases which are, or he believes to be, due to the patient's work or working conditions. In making his report the physician brings into play the immediate cooperative action of the Health Department which works with industry in correcting unsatisfactory conditions thus preventing the occurrence of similar diseases.

Huntington Williams, M.D.

* * * * * *

WORLD MEDICAL ASSOCIATION SPEAKERS

Dr. Alfred Blalock, surgeon-in-chief at the Johns Hopkins Hospital, Baltimore, and Dr. Nicholson J. Eastman, obstetrician-in-chief at the Johns Hopkins Hospital, Baltimore, will be guest-participants in panel discussions at the First Western Hemisphere Conference of the World Medical Association at Richmond, Va., on April 24, 1953.

HEARING SCHEDULED ON EXTRA PAY ISSUE IN MILITARY SERVICES

Capitol Clinic, A.M.A., Vol. 3, No. 49, December 9, 1952

A subcommittee of a civilian commission established by the Armed Forces to study the question of extra pay for certain types of military duty (incentive pay, hazardous duty, overseas allowances, etc.) will hold hearings December 15 in Washington. Witnesses from private organizations will be heard and the question of the $100 monthly special pay for physicians and dentists in the Armed Forces is expected to come up. The American Medical Association has submitted a statement and requested to be heard at the hearings.

State of Maryland Department of Health

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, January 2–29, 1953

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCAL	MUMPS	POLIOMYELITIS, PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																		
Local areas																		
Baltimore County	92	—	—	3	2	1	10	—	—	31	—	—	10	33	1	16	—	14
Anne Arundel	51	—	3	1	3	1	5	—	—	13	—	—	—	6	—	7	—	4
Howard	1	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	1
Harford	42	—	31	3	55	—	2	—	—	1	—	—	—	5	—	—	m-1	3
Carroll	1	—	2	—	2	—	1	—	—	—	—	—	—	1	—	3	—	2
Frederick	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	1
Washington	11	—	—	—	—	—	—	—	—	1	—	—	—	7	—	3	t-1	4
Allegany	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
Garrett	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	1
Montgomery	57	—	—	—	4	1	6	—	—	8	—	—	—	34	—	3	—	5
Pr. George's	34	—	1	—	2	1	8	—	—	17	—	—	—	14	—	1	—	5
Calvert	5	—	—	4	—	—	—	—	—	2	—	—	—	1	—	—	—	—
Charles	4	—	—	—	—	—	2	—	—	1	—	—	—	1	—	1	c-1	—
Saint Mary's	1	—	—	1	—	—	1	—	—	4	—	—	—	—	—	1	—	—
Cecil	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	3	—	1
Kent	4	—	—	—	—	—	1	—	—	7	—	—	—	—	—	—	—	—
Queen Anne's	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
Caroline	1	—	—	—	—	—	—	—	—	—	—	—	1	3	—	3	—	1
Talbot	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	c-1	2
Dorchester	2	—	—	—	1	—	4	—	—	1	—	—	—	2	—	—	—	2
Wicomico	9	—	—	—	1	—	1	—	—	—	—	—	—	3	1	8	—	1
Worcester	2	—	—	—	—	1	—	—	—	—	—	—	—	3	—	3	—	—
Somerset	—	—	—	—	—	—	—	—	—	—	—	1	—	4	—	2	—	—
Total Counties	318	0	37	12	70	5	41	0	0	86	0	1	11	122	2	59	—	49
Baltimore City	235	3	12	24	8	3	67	1	0	125	0	0	12	119	11	628	c-2	37
State																		
Jan. 2–29, 1953	553	3	49	36	78	8	108	1	0	211	0	1	23	241	13	687	—	86
Same period 1952	391	4	24	38	1582	9	116	2	0	97	3	4	17	205	13	507	—	52
5-year median	375	8	19	—	260	8	152	1	0	129	1	4	90	181	81	540	—	69
Cumulative totals																		
State																		
Year 1953 to date	553	3	49	36	78	8	108	1	0	211	0	1	23	241	13	687	—	86
Same period 1952	391	4	24	38	1582	9	116	2	0	97	3	4	17	205	13	507	—	52
5-year median	375	8	19	—	260	8	152	1	0	129	1	4	90	181	81	540	—	69

c = congenital syphilis under 1 year of age
e = infectious encephalitis
m = malaria contracted outside the U. S. A., residence not stated.
t = tularemia

There were 2 positive reports of rabies in dogs, 1 from Calvert County and 1 from Worcester County.

BLUE CROSS AND BLUE SHIELD

THE EMPLOYER AND BLUE CROSS-BLUE SHIELD

R. H. DABNEY*

The Blue Cross-Blue Shield subscriber who utilizes his membership to cover the expenses of his hospital and medical care quite naturally feels grateful to the doctors and hospitals who guide him toward better health. He is grateful to Blue Cross-Blue Shield for taking care of all or part of the bills. He may even be aware of the fact that there is a close relationship between those members of the team that helped him; that Maryland Hospital Service and Maryland Medical Service are, in effect, the agents of the hospitals and the doctors in bringing him the best treatment at a cost he can afford.

But there is another important figure in the background of the picture. It is the businessman: the employer whose cooperation made it possible for the working man to enjoy the benefits of the Plans.

The employer contributed a great deal more to the success of Blue Cross-Blue Shield than his permission to allow membership solicitation to be made on the job and to set up the simple system of payroll deduction of subscription charges on a group basis. The entire group principle is based on his willingness to work with other members of the community health team. Blue Cross and Blue Shield benefits and rates are predicated upon the group principle, namely, that an average selection of risk is obtained which, in turn, means low subscription rates. No health statement is needed, such as would be required if memberships were sold to individuals.

That our very existence is contingent upon the employers cooperation and sponsorship, we all know, but he benefits himself in many ways from Blue Cross and Blue Shield. He derives satisfaction from knowing that his employees are protected against hospital and medical bills. He recognizes that such protection gives the employee more peace of mind and less worry about his personal finances. He knows that it increases the respect of the employee for the company that makes his welfare a part of its personnel policies. He has learned that absenteeism due to illness and poor production on the job are lessened when the employees know that they can afford hospital and medical care at the first symptoms of sickness. In the long run, he finds that it pays in both good will and good business operation to encourage enrollment of his people in a Blue Cross-Blue Shield group. And, finally, looking beyond the doors of his own firm, he sees that he is contributing to the general welfare and good health of people in his community.

---

* Executive Director, Maryland Hospital Service, Inc., Maryland Medical Service, Inc.

BLUE CROSS, BLUE SHIELD; "INDEMNITY" OR "SERVICE"

OSBORNE D. CHRISTENSEN, M.D., D-OG, F.A.C.S.*

The voluntary hospital is an ever more efficient agent and has come a long way in the last 100 years. Originally conceived as a concentration point for the bedside care of hopeless invalids, few of whom expected to, or did, become rehabilitated; the converse is now so generally true that few expect otherwise.

Although the procedures that the physicians carry out and the medicines and biologicals they use have changed radically; the main services which the hospital renders are basically unchanged viz., housekeeping and nursing care for the sick patient, on the one hand; and technical aid to the physician, in his diagnostic or therapeutic efforts, on the other.

---

* Delegate from Wicomico County to the House of Delegates of the Medical and Chirurgical Faculty, 1952. Vice-President, Medical and Chirurgical Faculty, 1953.

The professional nurse is an important part of this complex and her intelligent dispatch of the systems of treatment, outlined by the physicians in charge, determines greatly the nature of the result.

The voluntary hospital was, from the beginning, a charitable and cooperative community answer to the problems of the sick patient; where the facilities could be maintained for all and a nominal charge be made to the users; except the poor. The more fortunate gave freely. The poor, in the real sense, have all but disappeared. Although many are most comfortable, few are sufficiently secure and substantial to consider themselves in the roles of personal philanthropists. The base had to be "broadened," but the hospital patient resisted, and rightly, to becoming the sole support of the hospital. The Blue Cross Plan was a splendid solution—a form of voluntary taxation, mutually levied on the potential users, in groups. The plan solved a difficult situation; but left much to be desired. The public which could prior scarce afford C.O.D. services, and seldom made provisions against the possibilities; now began to gather momentum as Pre-Paid Consumers.

The Pre-Paid Consumer begins his cycle with the natural relaxation of peace and protection; but he has repeatedly demonstrated his ability to develop a healthy, if not a voracious, appetite for things to which he is "entitled." Hospitalization; and its more expensive accessory goods, and services have proven no exception. This has become the kernel of every conference and meeting that is concerned with patient costs; and to postulate that the physicians have effective control and could limit the consumption of these goods and services is sheer fantasy, if not worse!

The lowered mortality and morbidity; and the generally pleasant air in hospitals today, has removed virtually all the deterrents that faced the potential patient; the last barrier is gone, or was, when full pre-payment appeared. To ask the physician to deny the subscriber his use of the Plan is asking him to correct an inherent fault too great; and a fault many physicians foresaw from the inception. The prohibitive cost of automobile collision insurance, except when on a deductible basis, suggests an approach toward an answer to this Pre-Paid Consumer whose appetite will one day exhaust the reserves; in short, nullify the purposes of the entire plan.

So much for the community's cooperative attempt, to find a satisfactory answer to the inadequate home sick-room; and which has evolved the modern voluntary hospital in America, a monument to devotion and service. The Blue Cross is an excellent attempt toward equitable finance, in the field of hospitalization, but some of its features have far reaching aspects deserving close and careful consideration.

The professional doctor and professional nurse are only by association part of the hospital; and in a sense the nurse is the liaison between doctor and hospital; all three rendering a distinct and indispensable service to the patient. The gradual merger of the vision of nurse and hospital has progressed to the point where the nurse, as an individual of professional ability is almost unnoticeable. This is to be deplored. The nurse should be a team member; cooperative but *professional*.

The nurse can hardly recall that her counterpart of a century ago once worked almost solely in patients homes. Not so the physician; his activities in the hospital have only recently become a major, albeit always important, part of the many functions of his profession. He has adapted himself and his patients to the hospital and it to him. He depends on the hospital, from a practical standpoint, but not fundamentally.

As to his services to the patient, they resist definition; and this is the key to a profession. The amount, type, scope and value of those services vary in an infinite number of ways and these are subject to change without notice; according to the giver and the receiver, and countless other factors. The custom of paying a fee for a professional service has long been justly honored as a solution; and no other profession can point to a more honorable record, of service to the needy save, perhaps, the clergy.

We are threatened by some politicians with *Federal* standardization of professional services for medicine; and wooed by well meaning friends and associates to join voluntarily in a Blue Shield Plan, whose aims and principles differ only in degree. This seems harsh but it is, at least, honest. The means of finance may belong to financiers and planners, but the agreement on the nature of the services, and the fees to be paid, in any given instance, is a matter to be settled between the parties involved—and this is a fundamental to a profession.

This author is concerned with but one issue; it lies between "Indemnity" and "Service" as the basis for payment of pre-paid medical insurance. The indemnity method protects the above defined fundamental and, in no way that is apparent, injures the policy holder. He can readily find treatment at the Service fee levels, *if* these are realistic; all factors being considered, including the momentary economic indices, both general and personal. What sufficient purpose, then, exists, for the profession to catalogue its services and offer them at pre-determined fixed fees? Let us not lose touch with the people. The arrival at an equitable fee must be a cherished privilege and recognized as a responsibility and a trust, of no less importance than the several other great keystones underlying the relationship between patient and physician. The "Indemnity" feature has desirable elasticity and will limit the endless pressures, conferences and debates, through which one group, and then another, will attempt to alter the details of payment, premiums and eligibility in a fixed-fee service plan.

Let us resist the continuation and expansion of the types of plans which catalogue fees exactly, and provide full pre-payment to the consumer. Inflexible to the physicians, taxing the thrifty user in favor of the less scrupulous—the so-called "Service" plans are a long step towards reducing the status of the profession, eliminating the physician as a free agent; and nullifying the value of money as a mode of exchange and a method of saving for future use, the fruits of one's present or past endeavors. Thus, both the subscriber and the physician are injured. The steadily climbing premium costs are mute testimony, and these are but a preview; for the plan administrators can not forever expect the luxury of claims even as low as now! How long will the private patient continue to build and furnish the hospitals while the Blue Cross patient enjoys a maintenance cost basis? How long will it take us to realize that these are not a few of our patients, but soon will be almost all?

Let us leave no stone unturned in a search for insurance against *catastrophe*, either sudden or chronic. This is the insurance every honest citizen wants. Let us, however, stand as a bulwark against signing the public and the profession to a contract which tends to standardize professional fees; must eventually lead to endless bickering between the representatives of the policy holders, hospitals, and professional groups—each anxious to obtain equity; whilst uncontrollable wastefulness makes a mockery of the entire proceedings!!

* * * * * *

1953 MEDICAL ORIENTATION CONFERENCES SECOND ARMY AREA

The Medical Section, Headquarters Second Army will conduct a series of Medical Orientation Conferences for Reserve Officers of the Army Medical Service in the Second Army Area. The meetings will be held in the following cities:

Cleveland, Ohio	14 March 1953
Cincinnati, Ohio	15 March 1953
Philadelphia, Pa.	21 March 1953
Pittsburgh, Pa.	22 March 1953
Richmond, Va.	28 March 1953
Baltimore, Md.	29 March 1953

For further information write to William S. Smith, Lieutenant Colonel, MC Chief, Operations Division Medical Section, Headquarters Second Army, Fort George G. Meade, Maryland.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. GEORGE H. YEAGER, *Auxiliary Editor*

OUR FIRST PARTY

MRS. E. ELLSWORTH COOK, JR.*

Now that our first dessert luncheon, fashion show and card party for the Baltimore City Auxiliary is successfully over, I can look back on it with a warm glow instead of a large question mark! Since this was our first venture into the social whirl, exact planning as to number of tables and chairs, table prizes, the amount of food to purchase, etc., was difficult. Hutzler Bros. who staged our fashion show, said that we must have a minimum of 300 people present to make it worth their while. We optimistically assured them of their minimum and promptly wondered where we could possibly sell that many tickets. Our ticket chairman, Mrs. Edwin H. Stewart, Jr., decided the best way was to contact each Auxiliary member by phone and ask her to be responsible for at least one table. This was not very difficult and everyone worked hard selling tickets!

Mrs. J. Carlton Wich

Mrs. Nathan Needle and Mrs. Irving Taylor, our fashion show chairmen, selected the models for the show from our membership. We purposely chose clothes for various age groups as well as in different sizes so as to make a more universal appeal. Having Auxiliary models not only saved us quite an expense, but it also added greatly to our fun. The corsages donated by The Avenue Florists for our models to wear made the evening gowns and our lovely wedding scene complete.

Mrs. Newland Day, Mrs. E. Ellsworth Cook, Jr., and Mrs. Ross Brooks

Mrs. Albert E. Goldstein, our President, saved the treasury another expense by securing a donation of Meadow Gold Ice Cream! We are indeed grateful both to the Company and to her because we can still remember how delicious it was. Our dessert Chairmen, Mrs. Ross Brooks and Mrs. Richard Garrett, served the guests ice cream, cake, and coffee, buffet style, which worked out very well. During the afternoon, cokes and chocolate home-made fudge were sold so rapidly that next year the amount of fudge made could be greatly increased.

---

* Chairman, Committee on Arrangements, Woman's Auxiliary to the Baltimore City Medical Society.

In the hallway, in an eye catching spot, was a beautifully arranged display of Christmas cards, wrappings, and ribbons. Mrs. John DeHoff and Mrs. Deonis Lupo were responsible for the Christmas table and were delighted at the many sales they made.

Another extra source of income was the raffle of a white cocktail hat. Mrs. John Norton was Chairman of the raffle. Mrs. Norton, one of the pretty models who consented to put on the hat and show everyone how becoming it was, put her hand in the raffle box and promptly drew out her own winning chance!

To compensate to the guests for not winning the hat, Mrs. Robert Berry and Mrs. Arthur Ward distributed numerous door prizes that thrilled their winners. The Bridge Chairman, Mrs. W. Kennedy Waller, is still receiving congratulations on her choice of such a novel bridge prize. It was a glass bottle with directions and ingredients for making several kinds of salad dressings.

One of our most important 'shots in the arm' was the valuable publicity Baltimore's two Newspapers gave us. Through the efforts of Mrs. J. Carlton Wich, the Benefit Publicity Chairman, there were two articles in each paper and two pictures one of the committee and the other of several models in the News Post.

Last, but not least, we were very fortunate in having the Medical and Chirurgical Faculty Building as the setting for our party. Not having to go to the expense of renting a room large enough was a primary factor towards our success. We also felt, sitting there among the portraits of famous doctors, that we were almost as welcome and as at home as they, at 'Med Chi'!

* * * * * *

SECOND ANNUAL PEDIATRIC SEMINAR*

Sunday, April 12, 1953

10:05–11:00 "Immunization Procedures in Pediatrics"
Dr. Aims C. McGuinness
Dean, Graduate School of Medicine
Assistant Professor of Pediatrics, University of Pennsylvania
11:00–11:30 "Discussion"
11:30–12:30 "The Common Respiratory Infections in Pediatric Practice"
Dr. Waldo E. Nelson
Professor of Pediatrics, Temple University, Philadelphia, Pennsylvania
12:30–1:00 "Discussion"
1:00–2:30 Lunch
2:30–3:30 "Emotional Problems of Children seen frequently in Pediatric Practice"
Dr. Leo Kanner
Professor of Psychiatry, Johns Hopkins Hospital
3:30–4:00 "Discussion"
4:00–5:00 "Common Urologic Problems in Children"
Dr. Meredith Campbell
Professor of Urology, New York University
5:00–5:30 "Discussion"

* For additional information contact Dr. J. Edmund Bradley, Pediatric Department, University of Maryland, School of Medicine, Baltimore 1, Maryland.

Ancillary News

BALTIMORE CITY DENTAL SOCIETY

A. BERNARD ESKOW, D.D.S., *Journal Representative*

The essayist at a recent meeting of the Baltimore City Dental Society was Dr. Louis I. Grossman, Associate Professor of Oral Medicine, University of Pennsylvania Dental School. His subject, "Poly-antibiotic Treatment of Root Canals" was quite interesting and informative.

At a later meeting Colonel Joseph L. Bernier, D.C., Chief, Dental and Oral Pathology Section, Armed Forces Institute of Pathology, was the speaker. He discussed "Oral Diagnosis with Particular Reference to Pre-Malignant and Malignant Diseases," and many complimentary remarks have been received about his lecture.

* * * * * *

First All-Faculty Dance!

A STATE-WIDE BALL WILL BE PART OF THE ANNUAL MEETING PROGRAM

April 27, 1953

Make reservations now for the "Evening in Paris" Ball to be held on Monday, April 27, 1953, from 9 until 1 A.M. at "The Alcazar" and sponsored by the Woman's Auxiliary to the Baltimore City Medical Society.

Black tie. Be a "Parisien," be a Patron and be THERE!

An early return of the form below will be appreciated. Please make checks payable to the Woman's Auxiliary to the Baltimore City Medical Society and mail to:

Mrs. E. Ellsworth Cook, Jr.
2431 Maryland Avenue
Baltimore 18, Maryland

- -

Please send me__________tickets at $3.00 per person, including tax.

Also enclosed please find $__________for the Patron List, at a Two Dollar Individual Minimum.

Name________________________________

Address______________________________

Maryland
STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 2 *March, 1953* NUMBER 3

EDITORIAL

RESPONSIBILITY

LESLIE E. DAUGHERTY, M.D.*

Medical care is a public trust. Those entrusted to the care of the sick mentally or physically, often times both, have a great responsibility. It cannot become machinelike and function as an assembly line, yet there are times when it needs streamlining. It is never static, must never pause because every accident, every illness is a new problem. New diseases and even new symptoms in old diseases arise, with new treatment; antibiotic, bacteriostatics, enzymes, ad infinitium constantly change the picture. A new perspective must be always before us. Thinking, while it will always be individual, must be correlated, assembled, compiled and treated collectively. It must be weighed and evaluated. New steps taken, must fit in and occasionally replace the old but never must the old when good, be laid aside until something better takes its place. New models do not come out every year, they happen everyday, almost every minute and so postgraduate work is necessary to keep abreast of the times. Every hospital should and could be, a postgraduate institution. Many are and others could be medical centers in every community. Not just for the sick, but for the well. Preventive medicine becomes more important everyday. The people want it, even demand it and if we the physicians and hospitals don't supply it, they get impatient. We should supply it, even before it is recognized by the public. Good relationship between the physicians and hospitals must be maintained. The artisan creates his masterpiece in the good workshop. It is true good minds think good anywhere, just so! immature minds are influenced by environment.

Physicians must be well educated. That is fully recognized, but even so they must keep abreast of the new discoveries, new techniques and management; that is the hospitals too must be constructed right and maintained right; considering always, sanitation, hygiene, ventilation, food, nursing and medical care of course, but not exclusively. Just so should all those, having to do with management keep abreast of the times; not only provide the essentials but seeing that the entire personnel is happy and contented. The ill especially are quick to sense harmony, system but not too much system, rules but not too many rules, innovations but not too many innovations; loyalty to the help, to the management, to the physicians, courtesy always.

Sickness is distressing to say the least and always annoying. Let one of our own be stricken, it affects our thinking, our actions, our consideration to others. Yes, instances are known where surgeons have gone right on with the operation, when notified of a fatal accident to their loved ones, but that is not the rule.

---

* Member of the Editorial Board, Maryland State Medical Journal.

Neither can we be too sentimental and/or too political. But, there is a middle ground; free discussions between the staff and the patients, the board of governors and the physicians, the physicians and the nurses and always, the patient with the nurses. Hospital costs and medical care would be better tolerated, if an explanation could be had. Certainly, a discussion between those involved could be undertaken often times to the good of both.

Physicians could and should be ambassadors of the hospital; in turn the hospitals, ambassadors of good will between the public and physicians and the nurses. "All to serve and serve to All."

* * * * * *

MAKE YOUR HOTEL RESERVATIONS NOW!

Annual Meeting of the Medical and Chirurgical Faculty
April 27, 28, and 29, 1953

In view of the shortage of hotel rooms in Baltimore City, members of the Medical and Chirurgical Faculty and the Woman's Auxiliary are urged to make their hotel reservations now for Monday night, April 27, 1953. This will insure your having accommodations in Baltimore in time for the Medical and Chirurgical Faculty Ball and, of course, for the scientific sessions of the Annual Meeting.

* * * * * *

AN INNOVATION
THE DANCE

A preliminary function preceding the Annual Meeting, Medical and Chirurgical Faculty, Monday, April 27, 1953, The Alcazar, 9 until 1.

For details and tickets write to Mrs. E. Ellsworth Cook, 2431 Maryland Avenue, Baltimore 18, Maryland.

* * * * * *

TABLES RESERVED FREE

While they last, tables may be reserved, without charge, for the Medical and Chirurgical Faculty Ball, to be held on Monday night, April 27th, at "The Alcazar" in Baltimore, as part of the Annual Meeting Program. Members of the Faculty or the Auxiliary may engage a table for ten simply by writing or telephoning Mrs. Newland E. Day, 3424 Guilford Terrace, Baltimore 18, Maryland. Telephone—HOpkins 2977.

ONE HUNDRED FIFTY-FIFTH ANNUAL MEETING

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

1211 Cathedral Street, Baltimore 1, Maryland

ANNUAL MEETING PROGRAM*

ALL FACULTY DANCE

MONDAY, APRIL 27, 1953 – 9:00 P.M. to 1:00 A.M.

THE ALCAZAR, Cathedral and Madison Streets

All the members, their wives, and guests are urged to attend THE DANCE (dress optional), which is under the sponsorship of the Woman's Auxiliary to the Baltimore City Medical Society. Tickets $3.00 per person and checks may be sent to Mrs. E. Ellsworth Cook, 2431 Maryland Avenue, Baltimore 18.

Tuesday, April 28, 1953

Morning Session

Maurice C. Pincoffs, M.D., *President*, Presiding

8:30 a.m. Registration. Also throughout meetings.

9:30 a.m. The Protean Clinical Features of Leptospirosis. (Illustrated)
Theodore E. Woodward, M.D., Associate Professor of Medicine, University of Maryland School of Medicine.

9:50 a.m. Iron Deficiency Anemias. (Illustrated)
Philip F. Wagley, M.D., Instructor in Medicine and Anatomy, The Johns Hopkins University School of Medicine.

10:10 a.m. Surgical Treatment of Aortic Aneurysms. (Illustrated)
Henry T. Bahnson, M.D., Assistant Professor of Surgery, The Johns Hopkins University School of Medicine.

10:30 a.m. A Factor in Repeated Abortions. (Illustrated)
Howard W. Jones, Jr., M.D., Instructor in Gynecology, The Johns Hopkins University School of Medicine.

10:50 a.m. Recess.

11:00 a.m. Indications and Results in Cardiac Surgery. (Illustrated)
Robert P. Glover, M.D., Clinical Professor of Surgery (Thoracic), Hahnemann Medical College and Temple University School of Medicine, Philadelphia, Pennsylvania.

11:20 a.m. Diagnosis and Treatment of Ringworm of the Scalp. (Illustrated)
Harry M. Robinson, Jr., M.D., Associate Professor of Dermatology, University of Maryland School of Medicine.

---

* Committee on Scientific Work and Arrangements, Beverley C. Compton, M.D., *Chairman*, William L. Garlick, M.D., and Edwin H. Stewart, Jr., M.D.

Tuesday Morning, April 28—Continued

11:40 a.m. Bone Bank. (Illustrated)
Henry G. Reeves, Jr., M.D., Assistant Resident in Surgery, University Hospital. (By invitation)

12:00 Noon Adjournment.

Afternoon Session

George O. Eaton, M.D., *Vice-President*, Presiding

2:00 p.m. Laboratory Tests in Common Endocrine Disorders. (Illustrated)
John G. Wiswell, M.D., Assistant Physician, Out-Patient Department, Department of Medicine, The Johns Hopkins Hospital. (By invitation)

2:20 p.m. Results of Operations for Disc Herniation With and Without Fusion. (Illustrated)
I. William Nachlas, M.D., Associate Professor in Orthopedic Surgery, The Johns Hopkins University School of Medicine.

2:40 p.m. Treatment of Benign Uterine Bleeding with Radium. (Illustrated)
J. Mason Hundley, Jr., M.D., Professor of Gynecology, University of Maryland School of Medicine.

3:00 p.m. Recess.

3:10 p.m. Interrelations of Thyroid and Iodine Metabolism. (Illustrated)
T. S. Danowski, M.D., Professor of Research Medicine, The University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania.

Harvey Grant Beck Memorial Lectureship

Abstract. The newer developments in the field of iodine and thyroid physiology make objective indices of thyroid activity all the more desirable. Enough data have now been accumulated to permit detailed discussion of the utility and limitation of protein-bound or serum precipitable iodine levels in establishing the status of thyroid function. It is known of course that the thyroid gland possesses the capacity, apparently unique among body organs and tissues, of removing halogens from the blood circulating through it. This halide is then coupled with the amino acid tyrosine; molecules of halogenated amino acids are united to form the thyroxine molecule. It enters the colloid for variable periods of storage prior to being released to the circulation, and to the tissues. In the plasma it is under ordinary circumstances present in the protein-bound or serum precipitable fraction of iodine. Our attention will in the main be focused upon physiological and clinical factors which produce alterations in this moiety.

3:40 p.m. The Young Primigravida.
John Huff Morrison, M.D., Associate in Obstetrics, University of Maryland School of Medicine.

4:00 p.m. Tendon Sutures. (Illustrated)
Erwin R. Jennings, M.D., Resident in Surgery, University Hospital. (By invitation)

4:20 p.m. Carcinoma of the Gall Bladder. (Illustrated)
George G. Finney, M.D., Assistant Professor of Surgery, The Johns Hopkins University School of Medicine.

4:40 p.m. Adjournment.

Evening Meeting

Maurice C. Pincoffs, M.D., *President*, Presiding

8:00 p.m. 1. Necrology. **A. S. Chalfant, M.D.,** Chairman, Memoir Committee.
2. Presidential Address. **Maurice C. Pincoffs, M.D.**

Tuesday Evening, April 28—Continued

3. The Surgical Treatment of Bleeding Esophageal Varices. (Illustrated)
Robert R. Linton, M.D., Assistant Clinical Professor of Surgery, Harvard Medical School, Visiting Surgeon and Chief of the Peripheral Vascular Clinic, Massachusetts General Hospital, Boston, Massachusetts.

John M. T. Finney Fund Lecture

Abstract. Massive bleeding from ruptured esophageal varices is one of the most serious complications of portal cirrhosis of the liver and the so-called Banti's Syndrome. A recent analysis of the problem at the Massachusetts General Hospital revealed that 99 patients had been admitted because of cirrhosis of the liver, during the five year period between 1946 and 1950 inclusive. Thirty-eight of these patients, or 58 per cent, died while in the hospital, and of utmost importance is the fact that hemorrhage from the esophageal varices played a major rôle in the deaths of 32, or 84 per cent of them. Further analysis revealed that exsanguination was the chief cause of death in 23, or 72 per cent of them, and in 9 others, or 28 per cent, death was due to liver failure precipitated by massive hemorrhage in each case. These figures demonstrate clearly that an early, effective and safe means of controlling the ruptured esophageal varix at the time of acute hemorrhage is necessary. The emergency methods of handling this problem will be discussed, with special reference to the use of balloon tamponade and a direct suture of the bleeding esophageal varices through a left thoracotomy incision. The results obtained in the definitive treatment of portal hypertension with bleeding esophageal varices by means of portacaval shunts will be given in a series of 80 patients operated upon at the Massachusetts General Hospital during the past seven years.

Wednesday, April 29, 1953

Morning Session

Osborne D. Christensen, M.D., *Vice-President*, Presiding

8:30 a.m. Registration. Also throughout meetings.

9:30 a.m. Forms of Purpura—Diagnosis and Treatment. (Illustrated)
Milton S. Sacks, M.D., Associate Professor of Medicine and Director of Clinical Pathology and Rh Laboratory, University of Maryland School of Medicine.

9:50 a.m. Uses and Misuses of Antibiotics in Skin Diseases. (Illustrated)
Israel Zeligman, M.D., Assistant Professor of Dermatology, University of Maryland School of Medicine.

10:10 a.m. Cystic Fibrosis of the Pancreas. (Illustrated)
Gordon E. Gibbs, Ph.D., M.D., Associate Professor of Clinical Research, University of Maryland School of Medicine.

10:30 a.m. Management of Convalescence and Later Life After Coronary Thrombosis. (Illustrated)
William S. Love, M.D., Associate Professor of Medicine and Chief of Section of Cardiology, University of Maryland School of Medicine.

10:50 a.m. Recess.

11:00 a.m. Medical and Surgical Treatment of Lung Abscess.
R Adams Cowley, M.D., Department of Thoracic Surgery, University of Maryland School of Medicine.

11:20 a.m. Hepatic Hypoglycemia in Congestive Heart Failure. (Illustrated)
Philip A. Tumulty, M.D., Associate Professor of Internal Medicine and Director of Medical Clinic, The Johns Hopkins University School of Medicine. (By invitation)

11:40 a.m. The Pharmaceutical Aspects of Prescription Writing. (Illustrated)
Noel E. Foss, Ph.D., Dean of the University of Maryland School of Pharmacy. (By invitation)

Wednesday Morning, April 29—Continued

12:00 Noon ELECTION OF THE BOARD OF MEDICAL EXAMINERS.
12:15 p.m. Adjournment.

12:30 p.m. Woman's Auxiliary Luncheon, Sheraton Belvedere Hotel, Baltimore.
Louis H. Bauer, M.D., President of the American Medical Association, Guest Speaker.
All Faculty members are invited and urged to attend

Afternoon Session

William F. Williams, M.D., *Vice-President*, Presiding

2:30 p.m. Current Views on Poliomyelitis. (Illustrated)
David Bodian, M.D., Associate Professor of Epidemiology, The Johns Hopkins University School of Hygiene and Public Health. (By invitation)

2:50 p.m. The Dione Drugs in Petit Mal Seizures. (Illustrated)
Ruth W. Baldwin, M.D., Director of Seizure Unit, Department of Pediatrics, University of Maryland School of Medicine.

3:10 p.m. The Clinical Value of Arteriography. (Illustrated)
E. Converse Peirce, 2nd, M.D., National Heart Institute (Resident in Surgery, U. S. Public Health Service Hospital, Baltimore).

3:30 p.m. Recess.

3:40 p.m. Orthopedic Problems of Children. (Illustrated)
James P. Miller, M.D., Chief Orthopedist, Veterans Administration Hospital, and Orthopedic Surgeon, The Johns Hopkins Hospital.

4:10 p.m. Cat Scratch Disease. (Illustrated)
Frank G. MacMurray, M.D., Clinical Instructor in Medicine, George Washington University School of Medicine, Washington, D. C.

4:30 p.m. The Nonoperative Treatment of Stress Incontinence in Women. (Illustrated)
Lawrence R. Wharton, Ph.B., M.D., Assistant Professor of Gynecology, The Johns Hopkins University School of Medicine.

4:50 p.m. Adjournment.

6:30 p.m.–7:30 p.m. BUFFET SUPPER, 1211 Cathedral Street.
The members are urged to bring their wives and guests.

Evening Meeting

Maurice C. Pincoffs, M.D., *President*, Presiding

8:00 p.m.
1. Introduction of **Louis H. Bauer, M.D.,** President, American Medical Association.
2. Introduction of **Mrs. Charles H. Williams,** President, Woman's Auxiliary to the Medical and Chirurgical Faculty.

(*Continued on next page*)

Wednesday Evening, April 29—Continued

3. The Changing Nature of Medicine.
   J. S. L. Browne, M.D.C.M., Ph.D., F.R.S.C., F.R.C.P.(C)., F.A.C.P., Professor of Medicine, McGill University, and Director, McGill University Clinic, Royal Victoria Hospital, Montreal, Canada.

I. Ridgeway Trimble Fund Lecture

ABSTRACT. In connection with a symposium entitled "The Criteria of Proof in Various Sciences" held some years ago, it was brought out that during the past decades there has been an alteration in the point of view of a number of different scientific disciplines. This is expressed by the physicists as the "Operational point of view" and one may say that the analogy of a "net" rather than a straight chain has come to be the concept of causality.

The development of physiology and biochemistry, of the concept of the adaptation syndrome and the effects of ACTH and Cortisone in a variety of diseases, has tended to break down the rigid idea of separate and distinct clinical entities each with its own name and to show that there is a large common element underlying them. This is a further development of the earlier concept of the Host Response.

This development has helped to accentuate the semantic difficulties and difficulties of communication between succeeding generations of medical men, between those engaged in the various and ever increasing compartments or specialties of medicine, and between the doctor and his patient.

A speculative discussion on the effect of these factors on medicine in general will be attempted.

ANNUAL MEETING—BUSINESS SESSIONS

CHRONOLOGICAL OUTLINE

MONDAY, APRIL 27, 1953

11:00 a.m. Council, Friedenwald Room, 1211 Cathedral Street.
1:00 p.m. Luncheon, Osler Hall, 1211 Cathedral Street.
2:00 p.m. House of Delegates, Deutsches Haus, second floor auditorium, 1212 Cathedral Street.

TUESDAY, APRIL 28, 1953

1:30 p.m. Council, Friedenwald Room, 1211 Cathedral Street.
2:00 p.m. House of Delegates, Deutsches Haus, second floor auditorium, 1212 Cathedral Street.

WEDNESDAY, APRIL 29, 1953

9:30 a.m. House of Delegates, Deutsches Haus, second floor auditorium, 1212 Cathedral Street.

* * * * *

THE COMMERCIAL EXHIBITS—TENT, SUPPER ROOM, and BASEMENT CORRIDOR

SEE THE CREATIVE ARTS SHOW

SECOND FLOOR, FRICK READING ROOM

TUESDAY AND WEDNESDAY, APRIL 28 and 29, 1953

9:00 a.m. until after the Evening Meetings

FOURTH ANNUAL MEETING—WOMAN'S AUXILIARY TO THE MEDICAL AND CHIRURGICAL FACULTY

Headquarters—Sheraton Belvedere Hotel

Meetings—Blue Room

Luncheon—Assembly Room

WEDNESDAY, APRIL 29, 1953

MRS. GEORGE E. URBAN, *Convention Chairman*

9:30 a.m. Registration.

10:00 a.m. Business Meeting. **Mrs. Charles H. Williams,** *President*, Presiding.
Election of Officers.

10:30 a.m. "Your Doctor" Film. Courtesy of American Medical Association.
Nurse Recruitment Films.
Panel Discussions. **Mrs. John G. Ball,** *President-elect*, Presiding.
State and County Chairmen Participating.

12:30 p.m. Luncheon.
Invocation. **Rev. L. Barrett Rice,** Epworth Methodist Church, Washington, D. C.
Address. **Louis H. Bauer, M.D.,** *President*, American Medical Association.

2:30 p.m. Fashion Show by Schleisner Company. Narrated.
Music by Jack Lederer.

Postconvention Board Meeting to be called by the President.

Evening Meeting. The ladies of the Auxiliary are cordially invited to join their husbands and attend the BUFFET SUPPER at 6:30 p.m., which will be followed by the evening meeting of the Medical and Chirurgical Faculty. These will be held at the Faculty Building, 1211 Cathedral Street.

* * * * *

Medical and Chirurgical Faculty Ball

MRS. E. ELLSWORTH COOK, JR.
General Chairman, Medical and Chirurgical Faculty Ball, Annual Meeting, 1953

Mrs. Ross C. Brooks
Chairman of the Dance

Mrs. Richard Garrett
Chairman of Tickets

Mrs. John De Hoff
Chairman of Program

Mrs. J. Arthur York
Chairman of Patrons

Mrs. Edwin Stewart
Chairman of Advertisers

Mrs. Raymond Markley
Chairman of Decorations

Mrs. W. Samuel Harris
Chairman of Rue de La Paix

Mrs. Philip Lerner
Chairman of Cake and Candy

Mrs. Harold Vyner
Chairman of Dolls

Mrs. W. Kennedy Waller
Chairman of French Perfume

Mrs. Daniel Pessagno
Chairman of Flower Girls

Mrs. James Russo
Co-Chairman of Flower Girls

Mrs. Irving Taylor
Chairman of Folies-Bare-Gere

Mrs. Joseph Sheehan
Chairman of French Fashions

Mrs. Harry Beck
Stage Manager

Mrs. John R. Davis
Co-Chairman of Telephone Committee

Mrs. Jack Rosin
Co-Chairman of Telephone Committee

Mrs. Hyman Schiff
Co-Chairman of Telephone Committee

Mrs. Harold Rosen
Accompanist

Mrs. J. Carlton Wich
Chairman of Publicity

Mrs. George H. Yeager
Public Relations

IMPORTANT NOTICE RELATIVE TO ADOPTION LAW

G. C. A. ANDERSON, ESQUIRE*

The attention of the medical profession is directed to the drastic character of the adoption law passed by the 1950 Legislature. This Law, being Chapter 63 of the Laws of Maryland of 1950, in substance provides that a child can only be adopted through a State Licensing Agency. The law purports to authorize the natural parent, brother or sister, to authorize an adoption, but this exception has been so construed that, at least, insofar as doctors are concerned, it is a snare and a delusion inviting doctors into trouble. The law, after providing for licensed child placement agencies, then provides as follows:

> "The placement of a child by any one other than a licensed child placement agency . . . natural parent or parents . . . is prohibited."

The word "placement" has been construed to mean any act furthering, aiding, or assisting an adoption. This is true *even if the aid or assistance is aid or assistance given by the physician to the natural parent at the request of the natural parent.* Thus, should a doctor be the means of bringing a natural parent and adopting parent together, the doctor is guilty of an act of placement, and subject to indictment and fine "not to exceed $500 or imprisonment not exceeding one year in the discretion of the Court." This is true if the doctor's only act is to suggest the name of a possible adopting parent, or the name of some one who may know of an adopting parent, and an adoption is the result.

Good faith and ignorance of the law is no defense. The doctor, though he acts with only the most humane motives, and only at the request of either party, has violated the law.

In the recent case of *Goodman vs. District of Columbia*, 50 A. (2d) 812, the Municipal Court of Appeals for the District of Columbia construed a similar act containing the above language. In this case a lawyer was employed by a wife in divorce proceedings. She was pregnant with an illegitimate child at the time, and asked the lawyer to find some one who would provide a good home for her child. The lawyer advised her to go to a Welfare Agency, or a certain Infants' Home of her own choosing. She rejected this advice as she had been in an orphanage, and did not wish her child brought up in such an institution; she insisted on having her child placed in a private home.

The lawyer finally told her that if he heard of any one who wanted a child, he would let her know. She then persisted in calling him at his home, and office, several times a week to inquire if he had heard of any one who would take her child. Finally, when she called about two months before the child was born, he told her he had learned of a couple interested in adopting a child, and that he would have them contact her. She told him she preferred to remain anonymous and did not wish to know the names of the prospective parties. The lawyer offered to talk to the prospective adopting parents and report to her and otherwise conclude the matter.

He was paid nothing, and was apparently motivated by only the best motives. However he was indicted, found guilty, and the verdict affirmed on appeal. The Court at page 814 said:

> "That appellant did these things without compensation, that he was animated by the most humane motives, that he was perhaps imposed upon by the mother or yielded in sheer pity to her cries of distress —all this we may concede. And all this appeals to our sympathy for him; but it cannot justify us in holding that his acts were within the law."

A similar case was recently tried in Maryland where a physician, acting in the best of faith, and for no reward, assisted in the placing of certain children. In one instance, his sole activity was to examine the pregnant woman at the request of her father, ascertain that she was pregnant, and suggested the name of a person who might be able to assist her in her trouble. He was paid $2.50 for the examination and never saw the patient again until after the child was born. Nevertheless he was found guilty on this count of the indictment.

This case was in the nature of a test case. The statute was upheld, and the doctor found guilty.

It is the desire of the Court before whom this case was tried; the State's Attorney's office; the various Welfare Agencies, and all parties in interest, that this entire matter be given the widest publicity in order that other physicians, acting in the best of faith, be not caught within the terms of this Statute. Other physicians will not be able to plead ignorance in mitigation of sentence, since this case should put all on notice.

The following is a list of all licensed agencies as of the present time. This list is subject to change. A complete and up-to-date list can always be obtained from the State Department of Public Welfare, 120 W. Redwood Street, Baltimore 1.

---

* Attorney, Medical and Chirurgical Faculty.

Agency	*Area*
Allegany County Welfare Board 301 Cumberland St., Cumberland Religion—Any	Allegany Co.
Anne Arundel County Welfare Board South & Cathedral Sts., Annapolis Religion—Any	Anne Arundel Co.
Associated Catholic Charities, Inc. 415 Cathedral St., Baltimore 1 Religion—Catholic	Baltimore City, adjacent counties & Western Md.
Baltimore City Dept. of Public Welfare 327 St. Paul Place, Baltimore 2 Religion—Any	Baltimore City
Balto. Co. Children's Aid & Family Service Society, Inc. 105 E. Joppa Rd., Towson 4 Religion—Protestant	Baltimore Co.
Baltimore County Welfare Board 209 Washington Ave., Towson 4 Religion—Any	Baltimore Co.
Baptist Children's Aid Society 100 E. 23rd St., Baltimore 18 Religion—Baptist	Maryland
Barker Foundation, Inc. (adoption only) 6900 Wisconsin Ave., Bethesda 14 Religion—Any	Southern Md.
Board of Child Care 516 N. Charles St., Baltimore 1 Religion—Methodist	Maryland
Board of Public Welfare 815 Rhode Island Ave., N.W., Wash. 1 Religion—Any	Southern Md.
Calvert County Welfare Board Turner Bldg., Prince Frederick Religion—Any	Calvert Co.
Caroline County Welfare Board Law Bldg., Denton Religion—Any	Caroline Co.
Carroll County Children's Aid Society Albaugh-Babylon Bldg., Westminster Religion—Any	Carroll Co.
Carroll County Welfare Board 4 John St., Westminster Religion—Any	Carroll Co.
Catholic Charities of Washington, D. C. 1441 Rhode Island Ave., N.W., Wash. 5 Religion—Catholic	Southern Md.
Catholic Charities of Prince George's Co. 3723 34th St., Mt. Rainier Religion—Catholic	Southern Md.
Cecil County Children's Aid Society Room 301, Court House, Elkton Religion—Any	Cecil Co.
Cecil County Welfare Board Rooms 303–307, Court House, Elkton Religion—Any	Cecil Co.
Charles County Children's Aid Society Box 183, LaPlata Religion—Any	Charles Co.
Charles County Welfare Board Times-Crescent Bldg., LaPlata Religion—Any	Charles Co.
Church Mission of Help (adoption only) 105 W. Monument St., Baltimore 1 Religion—Protestant	Maryland
Dorchester County Welfare Board 112 High St., Cambridge Religion—Any	Dorchester Co.
Family & Child Services of Washington, D. C. 1907 S St., N.W., Washington 9 Religion—Protestant	Montgomery Co.
Family & Children's Society 204 W. Lanvale St., Baltimore 17 Religion—Protestant	Baltimore City & adjacent counties
Frederick Co. Children's Aid Society 14 E. Church St., Frederick Religion—Any	Frederick Co.
Garrett County Welfare Board First National Bank Bldg., Oakland Religion—Any	Garrett Co.
Harford County Welfare Board Bel Air Rd. nr. Kenmore Inn, Bel Air Religion—Any	Harford Co.
Howard County Welfare Board Main St. & Church Rd., Ellicott City Religion—Any	Howard Co.
Jewish Family & Children's Bureau 319 W. Monument St., Baltimore 1 Religion—Jewish	Baltimore City
Jewish Social Service Agency 1131 Spring Rd., N.W., Washington 10 Religion—Jewish	Southern Md.
Kent-Queen Anne Co. Children's Aid Society Chestertown Religion—Any	Kent-Queen Anne Co.'s
Maryland Children's Aid Society 2133 Maryland Ave., Baltimore 18 Religion—Any	Howard, Calvert Co.'s
Montgomery Co. Social Service League 104 S. Perry St., Rockville Religion—Any	Montgomery Co.
Montgomery County Welfare Board Montgomery Ave. & Monroe St., Rockville Religion—Any	Montgomery Co.
Prince George's County Welfare Board County Service Bldg., Hyattsville Religion—Any	Pr. George's Co.
Queen Anne's County Welfare Board Centreville, Md. Religion—Any	Queen Anne's Co.
St. Ann's Infant Home 2200 California St., N.W., Washington 8 Religion—Catholic	Southern Md.
St. Mary's County Welfare Board County Office Bldg., Leonardtown Religion—Any	St. Mary's Co.
Somerset County Welfare Board Somerset Ave., Princess Anne Religion—Any	Somerset Co.
Talbot County Children's Aid Society Easton, Md. Religion—Any	Talbot Co.
Talbot County Welfare Board County Bldg., Easton Religion—Any	Talbot Co.
Washington County Welfare Board 101 W. Antietam St., Hagerstown Religion—Any	Washington Co.
Wicomico County Welfare Board Railroad Ave., Salisbury Religion—Any	Wicomico Co.
Worcester County Welfare Board Green & Bank Sts., Snow Hill Religion—Any	Worcester Co.

PRESIDENTIAL APPOINTMENTS

Dr. Maurice C. Pincoffs, the President, has appointed the following Medical and Chirurgical Faculty Committees for 1953:

COMMITTEE TO ADVISE THE STATE INDUSTRIAL ACCIDENT COMMISSION:

Charles W. Maxson, *Chairman*, Baltimore, William J. Coleman, Baltimore, George O. Eaton, Baltimore, William R. Geraghty, Baltimore, Donald B. Grove, Cumberland, Howard M. Kern, Baltimore, James W. Nelson, Baltimore, Edward P. Thomas, Frederick.

ADVISORY COMMITTEE TO THE STATE HEALTH DEPARTMENT (the Committee to consist of the President, the President-elect, two Past Presidents, the Secretary and four general practitioners of which one represents the Maryland Academy of General Practice):

Alan M. Chesney, *Chairman*, Baltimore, Maurice C. Pincoffs, Baltimore, *President-Elect* (not elected until April 1953), Walter D. Wise, Baltimore, George H. Yeager, Baltimore, E. Paul Knotts, Denton, Robert S. McCeney, Laurel, Charles H. Williams, Pikesville, I. M. Zimmerman, Williamsport.

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY:

Samuel McLanahan, *Chairman*, Baltimore, William K. Diehl, Baltimore, William D. Noble, Easton.

ARMY MEDICAL LIBRARY COMMITTEE:

Thomas S. Cullen, *Chairman*, Baltimore, Andrew C. Gillis, Baltimore, John T. King, Baltimore, John E. Savage, Baltimore, Lawrence R. Wharton, Baltimore, Samuel Wolman, Baltimore.

BLOOD BANK ADVISORY COMMITTEE:

Merrell L. Stout, *Chairman*, Baltimore, C. Lockard Conley, Baltimore, Kendrick McCullough, Parsonsburg, Walter C. Merkel, Baltimore, H. Raymond Peters, Baltimore, Milton S. Sacks, Baltimore, Benedict Skitarelic, Cumberland, John Whitridge, Jr., Baltimore.

CANCER COMMITTEE:

J. Mason Hundley, Jr., *Chairman*, Baltimore, C. Bernard Brack, Baltimore, L. H. Brumback, Hagerstown, L. Clarence Cohn, Baltimore, Beverley C. Compton, Baltimore, William K. Diehl, Baltimore, Everett S. Diggs, Baltimore, Wylie M. Faw, Jr., Cumberland, Gerald A. Galvin, Baltimore, Howard W. Jones, Jr., Baltimore, James T. Marsh, Westminster, William Neill, Jr., Baltimore, William D. Noble, Easton, Arthur G. Siwinski, Baltimore, Edwin H. Stewart, Jr., Baltimore, Richard W. TeLinde, Baltimore, James B. Thomas, Frederick, Grant E. Ward, Baltimore.

COMMITTEE TO CONSIDER THE RELATIONSHIP BETWEEN HOSPITALS AND SPECIALTIES AND THE MANNER OF PAYMENT FOR PROFESSIONAL SERVICES:

Webster H. Brown, *Chairman*, Baltimore, E. Hollister Davis, Baltimore, Merrell L. Stout, Baltimore, Henry L. Wollenweber, Baltimore.

COMMITTEE ON THE CONSTITUTION AND BY-LAWS:

A. Austin Pearre, *Chairman*, Frederick, E. Cowles Andrus, Baltimore, Donald Hooker, Annapolis, W. Houston Toulson, Baltimore.

COMMITTEE TO COOPERATE WITH AMERICAN MEDICAL EDUCATION FOUNDATION:

Newland E. Day, *Chairman*, Baltimore, Thurston R. Adams, Baltimore, Walter A. Baetjer, Baltimore, John G. Ball, Bethesda (Montgomery County), J. H. Bates, Elkton (Cecil County), Katherine A. Chapman, Kensington (Montgomery County), Stuart Christhilf, Jr., Annapolis (Anne Arundel County), H. V. Davis, Chesapeake City (Cecil County), Wilfred W. Eastman, Silver Springs (Montgomery County), Charles R. Foutz, Westminster (Carroll County), J. Stanley Grabill, Mt. Airy (Frederick County), Donald B. Grove, Cumberland (Allegany-Garrett), William B. Hagan, Mt. Rainier (Prince George's County), L. A. Hoffman, Hagerstown (Washington County), Philip A. Insley, Salisbury (Wicomico), W. O. McLane, Jr., Frostburg (Allegany-Garrett), Ernest F. Poole, Hagerstown (Washington County), Paul H. Royse, Pikesville (Baltimore County), Theodore R. Shrop, Ellicott City (Howard County), M. H. Sprecher, Elkton (Cecil County).

DIABETIC DETECTION COMMITTEE:

J. Sheldon Eastland, *Chairman*, Baltimore, E. Irving Baumgartner, Oakland, T. Nelson Carey, Baltimore, James D. Carr, Baltimore, J. Wilfrid Davis, Baltimore, Perry Futterman, Baltimore, Frank J. Geraghty, Baltimore, David J. Gilmore, Salisbury, Lewis P. Gundry, Baltimore, J. Roy Guyther, Mechanicsville, John H. Hornbaker, Hagerstown, Benjamin F. Jones, Baltimore, Charles F. O'Donnell, Towson, Harold Plummer, Preston, J. Emmett Queen, Baltimore, George G. Schlesinger, Baltimore, Frank M. Shipley, Annapolis, A. A. Silver, Baltimore, Benedict Skitarelic, Cumberland, Lester A. Wall, Jr., Baltimore.

EUGENE FAUNTLEROY CORDELL FUND COMMITTEE:

T. Nelson Carey, *Chairman*, Baltimore, James K. Gray, Thurmont, William L. Howard, Salisbury, Frank F. Lusby, Hagerstown, George Allen Moulton, Jr., Westminster.

COMMITTEE ON INDUSTRIAL HEALTH:

Nathan B. Herman, *Chairman*, Baltimore, Robert Van Lieu Campbell, Hagerstown, Robert F. Chenowith, Baltimore, Walter E. Fleischer, Baltimore, William L. Garlick, Baltimore, Hugh C. Gill, Sparrows Point, W. R. Hodges, Jr., Cumberland, John V. Hopkins, Baltimore, Robert H. Riley, ex officio, Catonsville, Benjamin H. Rutledge, Baltimore, Leroy W. Saunders, Baltimore, W. Kennedy Waller, Baltimore, William F. Williams, Cumberland, Huntington Williams, ex officio, Baltimore.

JOINT COMMITTEE WITH THE BAR ASSOCIATIONS ON MEDICOLEGAL PROBLEMS:

Louis Krause, *Chairman*, Baltimore, Conrad Acton, Baltimore, Leo Brady, Baltimore, Russell S. Fisher, Towson, Manfred S. Guttmacher, Baltimore, R. Carmichael Tilghman, Baltimore, I. Ridgeway Trimble, Baltimore, Henry F. Ullrich, Baltimore, Thomas Conrad Wolff, Baltimore, Charles A. Reifschneider, Baltimore.

LEGISLATIVE COMMITTEE:

Karl F. Mech, *Chairman*, Baltimore, Frederic V. Beitler, Halethorpe, Thomas A. Christensen, College Park, George O. Eaton, Baltimore, Raymond F. Helfrich, Baltimore, Norbert C. Nitsch, Baltimore, Willard S. Parsons, Baltimore, Daniel J. Pessagno, Baltimore, J. G. F. Smith, Brunswick, James E. Stoner, Jr., Walkersville, George E. Urban, Catonsville, I. M. Zimmerman, Williamsport. Each Component Society is represented by the incumbent President, Secretary, and Treasurer.

MATERNAL AND CHILD WELFARE COMMITTEE:

Louis H. Douglass, *Chairman*, Baltimore, J. Edmund Bradley, *Vice-Chairman*, Baltimore, George W. Anderson, Baltimore, J. Tyler Baker, Easton, John McF. Bergland, Baltimore, Annie M. Bestebreurtje, Baltimore, Harry D. Bowman, Hagerstown, Thomas A. Christensen, College Park, Stuart Christhilf, Jr., Annapolis, George H. Davis, Baltimore, Darius McC. Dixon, Baltimore, Nicholson J. Eastman, Baltimore, H. W. Eliason, Cumberland, A. H. Finkelstein, Baltimore, S. Butler Grimes, Baltimore, Wilson Grubb, Baltimore, Russell L. Guest, Frederick, I. R. Hanson, Salisbury, Virginia G. Harris, La Plata, Paul Harper, Baltimore, John S. Haught, Mt. Rainier, W. Royce Hodges, Jr., Cumberland, William K. Mansfield, Baltimore, William C. Morgan, Salisbury, J. Morris Reese, Lutherville, John E. Savage, Baltimore, Alexander J. Schaffer, Baltimore, Francis F. Schwentker, Baltimore, William C. Stifler, Jr., Baltimore, Byron D. White, Frederick, John Whitridge, Jr., Baltimore.

COMMITTEE ON MEDICAL RESEARCH:

R. Walter Graham, Jr., *Chairman*, Baltimore, Alfred Blalock, Baltimore, C. R. Edwards, Baltimore, Warfield M. Firor, Baltimore, Wetherbee Fort, Baltimore, Albert E. Goldstein, Baltimore, John H. Hornbaker, Hagerstown, David I. Macht, Baltimore, L. A. Rademaker, Salisbury, W. Alfred Van Ormer, Cumberland, Theodore E. Woodward, Baltimore, George H. Yeager, Baltimore, Alan M. Chesney, Baltimore (ex officio), H. Boyd Wylie, Baltimore (ex officio).

MEMOIR COMMITTEE:

A. S. Chalfant, *Chairman*, Baltimore, Harry D. Bowman, Hagerstown, Lynn H. Brumback, Hagerstown, F. A. Camalier, Leonardtown, W. N. Palmer, Easton.

MENTAL HYGIENE COMMITTEE:

Harry M. Murdock, *Chairman*, Towson, Dexter M. Bullard, Rockville, Robert E. Gardner, Sykesville, Kenneth B. Jones, Church Creek, Wendell S. Muncie, Baltimore, H. Whitman Newell, Baltimore, Irving J. Spear, Baltimore, Ralph P. Truitt, Baltimore.

COMMITTEE ON NATIONAL EMERGENCY MEDICAL SERVICE:

Robert H. Riley, *Chairman*, Baltimore, J. Albert Chatard, Baltimore, Alan M. Chesney, Baltimore, C. Reid Edwards, Baltimore, Charles W. Maxson, Baltimore, Walter D. Wise, Baltimore, George H. Yeager, Baltimore, Mr. George Buck, Baltimore, Mr. Walter N. Kirkman, Baltimore.

NEW BUILDING COMMITTEE:

C. Reid Edwards, *General Chairman*, Baltimore, Albert E. Goldstein, *Chairman*, *Finance Committee*, Baltimore, John W. Parsons, *Treasurer*, *Finance Committee*, Baltimore, R. Walter Graham, Jr., *Chairman*, *Building Plans*, Baltimore, Harry C. Hull, Baltimore, I. R. Trimble, Baltimore.

Subcommittee—Finance Committee

Warde B. Allan, Baltimore, James G. Arnold, Jr., Baltimore, John A. Askin, Baltimore, Walter A. Baetjer, Baltimore, Alan Bernstein, Baltimore, C. Bernard Brack, Baltimore, Leo Brady, Baltimore, Otto C. Brantigan, Baltimore, Henry A. Briele, Salisbury, Webster H. Brown, Baltimore, Edwin N. Broyles, Baltimore, Ferdinand E. Chatard, IV, Baltimore, Beverley C. Compton, Baltimore, Louis C. Dobihal, Baltimore, Louis H. Douglass, Baltimore, Monte Edwards, Baltimore, W. R. Ferguson, Baltimore, J. M. T. Finney, Jr., Baltimore, Wetherbee Fort, Baltimore, Frank J. Geraghty, Baltimore, Thomas K. Galvin, Baltimore, Mark E. Gann, Baltimore, Robert W. Garis, Baltimore, Lewis P. Gundry, Baltimore, Louis P. Hamburger, Sr., Baltimore, H. Hanford Hopkins, Baltimore, Harry C. Hull, Baltimore, J. Mason Hundley, Jr., Baltimore, Page C. Jett, Prince Frederick, Hugh J. Jewett, Baltimore, Marius P. Johnson, Baltimore, John T. King, Baltimore, E. Paul Knotts, Denton, Leon A. Kochman, Baltimore, Amos R. Koontz, Baltimore, Edward F. Lewison, Baltimore, E. T. Lisansky, Baltimore, Helen I. Maginnis, Baltimore, W. Kenneth Mansfield, Baltimore, Erwin E. Mayer, Baltimore, Karl F. Mech, Baltimore, Waldo B. Moyers, Mt. Rainier, W. Raymond McKenzie, Baltimore, Samuel McLanahan, Baltimore, Emil Novak, Baltimore, Frank J. Otenasek, Baltimore, Daniel J. Pessagno, Baltimore, Esther L. Richards, Baltimore, Harry M. Robinson, Jr., Baltimore, Fred B. Smith, Baltimore, Howard C. Smith, Baltimore, Richard W. TeLinde, Baltimore, Edward P. Thomas, Frederick, Rayond K. Thompson, Baltimore, W. Houston Toulson, Baltimore, I. Ridgeway Trimble, Baltimore, Henry F. Ullrich, Baltimore, Grant E. Ward, Baltimore, Lawrence R. Wharton, Baltimore, W. L. Winkenwerder, Baltimore, Walter D. Wise, Baltimore, Henry Wollenweber, Baltimore, Austin H. Wood, Baltimore, James D. Woodruff, Baltimore, Alan C. Woods, Baltimore, Israel S. Zinberg, Baltimore.

PHYSIOTHERAPY COMMITTEE:

W. Richard Ferguson, *Chairman*, Baltimore, Moses Gellman, Baltimore, H. Alvan Jones, Baltimore, Howard F. Kinnamon, Easton, C. Arthur Rossberg, Baltimore, Allen F. Voshell, Baltimore.

POSTGRADUATE EDUCATIONAL COMMITTEE:

Edward S. Stafford, *Chairman*, Baltimore, John McC. Culler, Frederick, Robert E. Farber, Sparrows Point, George J. Kreis, Jr., Elkton, James T. Marsh, Westminster, Claude W. Mitchell, Silver Spring, Robert B. Sasscer, Upper Marlboro, Edward J. Simon, Havre de Grace, Elizabeth P. Trevett, Annapolis, Louis S. Welty, Easton, Walter L. Winkenwerder, Baltimore.

COMMITTEE ON PUBLIC INSTRUCTION:

Huntington Williams, *Chairman*, Baltimore, E. I. Baumgartner, Oakland, Page C. Jett, Prince Frederick, William D. Noble, Easton, Robert H. Riley, Baltimore, Peter P. Rodman, Aberdeen, A. F. Whitsitt, Chestertown, Frank D. Worthington, Frederick.

COMMITTEE ON RURAL MEDICINE:

Page C. Jett, *Chairman*, Prince Frederick, Morris Franklin Birely, Thurmont, Arthur Talbot Brice, Jefferson, Thomas A. Christensen, College Park, P. E. Cox, Easton, Louis H. Douglass, Baltimore, John Fawsett, Boyds, J. Stanley Grabill, Mt. Airy, John H. Griffin, Hughesville, James W. Meade, Jr., Fishing Creek, Harold B. Plummer, Preston, Ernest S. Poole, Hagerstown, Perry F. Prather, Baltimore, Walter H. Shealy, Sharpsburg, H. J. Slusher, Frederick, Milford H. Sprecher, Elkton.

SCIENTIFIC SPEAKERS BUREAU:

Beverley C. Compton, *Chairman*, Baltimore, Alan M. Chesney, Baltimore, I. Ridgeway Trimble, Baltimore, Theodore E. Woodward, Baltimore, H. Boyd Wylie (ex officio), Baltimore.

COMMITTEE FOR THE STUDY OF PELVIC CANCER:

Richard W. TeLinde, *Chairman*, Baltimore, J. Mason Hundley, Jr., *Vice-Chairman*, Baltimore, Beverley C. Compton, *Secretary-Treasurer*, Baltimore, C. Bernard Brack, Baltimore, Robert N. Cooley, Baltimore, Charles N. Davidson, Baltimore, Everett S. Diggs, Baltimore, Howard W. Jones, Jr., Baltimore, Theodore Kardash, Baltimore, Emil Novak, Baltimore, Mark V. Ziegler, Brookeville.

TUBERCULOSIS COMMITTEE:

Lawrence M. Serra, *Chairman*, Baltimore, Edmund G. Beacham, Baltimore, Otto C. Brantigan, Baltimore, Leon Hetherington, Baltimore, H. Vernon Langeluttig, Baltimore, Isadore Lyon, State Sanatorium, John E. Miller, Baltimore, Hugh G. Whitehead, Jr., Baltimore, Samuel Wolman, Baltimore.

* * * * *

COURSE IN ELECTROCARDIOGRAPHY

Under the auspices of the Baltimore City Medical Society, every Tuesday Evening at 8:00 p.m., in the Auditorium of the Nurses Home of the Union Memorial Hospital

March 3, 1953	The Normal Electrocardiogram	Samuel Whitehouse, M.D.
March 10, 1953	The "Strain Patterns"	William F. Renner, M.D.
March 17, 1953	Myocardial Infarction	Abraham Genecin, M.D.
March 24, 1953	Myocardial Infarction	Abraham Genecin, M.D.
March 31, 1953	Bundle Branch Block AV Block	Caroline B. Thomas, M.D.
April 7, 1953	The Auricular Arrhythmias	William S. Love, M.D.
April 14, 1953	The Ventricular Arrhythmias Effect of Drugs	Robert E. Mason, M.D.
April 21, 1953	Congenital Heart Disease Wolf-White-Parkinson Syndrome Some Complex Arrhythmias	Leonard C. Akman, M.D.
April 28, 1953	Rheumatic and Other Infectious Diseases Endocrine and Metabolic Disturbances Electrolyte Effects	Katherine H. Borkovich, M.D.

SYMPOSIUM ON EUTHANASIA[1]

INTRODUCTION

JOHN S. STANLEY, ESQUIRE, *Moderator*[2]

Ladies and Gentlemen, this is the Third Symposium to be conducted by the Medical-Legal Committee of the Medical and Chirurgical Faculty, the Bar Association of Baltimore City, and the Maryland State Bar Association. The subject is "Euthanasia."

I am advised that euthanasia is defined in its common concept as "the painless killing of those incurably ill and under great suffering."

The procedure will be as follows: There will be the presentation of the legal, the philosophical and historical, and the medical aspects of this subject, presented by a lawyer, a professor of philosophy, and a doctor.

After that there will be a Panel discussion, a question-and-answer period. First there will be submitted to the members of this Panel certain questions which have been prepared by members of the Medical-Legal Committee and of the Panel. Questions are invited from the floor.

It has been found from experience that it is necessary to request that these questions be reduced to writing. For that purpose there are pads of paper on the chairs. Written questions will be taken up by ushers at the conclusion of the third address, that upon the subject of the medical aspects of euthanasia.

If time is available after that, the meeting will be open to discussion from the floor.

My remarks in introducing the speakers, at their request, will be extremely short. There are two reasons for this: First, because these three gentlemen are very well known in their respective professions, so that any extended remarks in presenting them would be entirely unnecessary. The second reason is that a maximum amount of time of the audience may be spent in listening to the Panel and a minimum amount of time will be required to listen to the Moderator.

The legal aspects of this subject will be presented by a lawyer, a younger lawyer of this City, who has recently resigned, after four years' experience as an Assistant State's Attorney of Baltimore City.

It gives me great pleasure to present to you Mr. Charles E. Orth, Jr.

---

[1] Arranged by the Joint Committee on Medicolegal Problems of the Baltimore and Maryland Bar Associations and the Medical and Chirurgical Faculty, under the auspices of the Symposia Management Subcommittee.

[2] President, Maryland State Bar Association.

LEGAL ASPECTS RELATING TO EUTHANASIA

CHARLES E. ORTH, JR., ESQUIRE[3]

I thank you, Mr. Stanley.

Mr. Layman: I read in the papers a short time ago that a young child was suffering from a chronic kidney disease. Her mother, who was a medical doctor, stayed up night after night trying to relieve her child's agony. Finally the mother broke under the strain and gave her child an anesthetic, then poison and later, seeing that her child was dead, tried to commit suicide with the same poison. Is that mother a criminal and liable to criminal prosecution?

Mr. Lawyer: When you ask whether the mother is a criminal you are dealing in a definition of terms. If you mean by "criminal" has she committed a crime, the answer is yes and she is liable to criminal prosecution. What she has done, in addition to the crime of attempted suicide, is to commit what is popularly known as a "mercy killing" or she has performed euthanasia, considering the term in its less technical sense. Let us look at another example, embodying the extreme, perhaps, in legal questions. Suppose that Miss A's brother is seriously ill. He has been in great pain for a long time and medical science cannot entirely alleviate that pain. Miss A has obtained for him the best treatment possible and the diagnosis and prognosis of all the doctors are the same—Mr. A has an incurable disease and he will eventually die after great suffering. Mr. A begs his sister to kill him or make it possible for him to kill himself. Finally, in desperation, she agrees. Motivated only by the love for her brother and at his request, she places by his bedside an overdose of a narcotic so he may take it. While she watches, he takes it and dies. Miss A has committed the crime of murder in the first degree and upon conviction shall suffer death or confinement for the period of her natural life (1).

---

[3] Formerly Assistant State's Attorney of Baltimore City.

Mr. Layman: That's difficult for me to understand. You certainly do not have a murderer in the accepted sense of the word. Miss A had only the best of intentions. She had no ill will or hatred for her brother. She was not motivated by personal gain nor did she act from jealousy or in passion. As a matter of fact, she did not even actually give him the drug; he took it himself. Further he was going to die anyway and she made the drug available only to relieve his suffering. How can she be guilty of murder and especially murder in the first degree?

Mr. Lawyer: Bear in mind that we are not concerned at this time whether or not her act *should* be legal or illegal but only whether or not it *is* legal or illegal. Therefore we cannot be concerned with the many other considerations surrounding her act—the religious, ethical, professional, social, philosophical and moral factors, for example. Nor are we concerned, at this time, with the evidentiary questions that might arise in such a situation. We are assuming that the facts as stated can be proved. On that premise, then, Miss A has committed murder in the first degree. Let me say this first. The law, and I refer particularly to the common law which is our heritage from England, is to be distinguished

> "... for its all embracing and salutary solicitude for the sacredness of human life, and the personal safety of the human being. This protecting paternal care envelopes every individual like the air he breathes.... The common law stands as a general guardian holding its aegis to protect the life of all. Any theory which robs the law of this salutary power is not likely to meet with favor." (2)

But you asked, why murder in the first degree? Again we need a definition of terms. Miss A has committed a homicide, that is, the killing of a human being by another human being. If such a killing is done by an act designed to take human life, it is felonious homicide. Felonious homicide is divided into murder and manslaughter. If the act is done with "malice aforethought," it is murder; if it is done without "malice aforethought," it is manslaughter.

Mr. Layman: Malice! Where was there any malice in what Miss A did?

Mr. Lawyer: The legal and popular conceptions of malice are entirely different. Legally "malice" includes not only anger, hatred or revenge but every unlawful motive. It is not confined to ill will to any one or more particular persons but it is intended to denote an action done with a wrongful intention. As Mr. Wharton states in his work on Homicide, giving the common law definition, malice is

> "When one with a sedate and deliberate mind and formed design doth kill another, which formed design is evidenced by external circumstances discovering the inward intention ... An actual or deliberate intention to take the life of another or do him great bodily harm from which death might probably result constitutes express malice ... it ... is inferred from circumstances attending the act of killing and is proved by circumstances evidencing a sedate purpose and formed design to kill another." (3)

So malice is present when an actual intent is entertained to cause death and an act is done in furtherance of that criminal design. It is not necessary that express malice, in the sense of hatred and malevolence toward the deceased, be shown in order to support a verdict of murder in the first degree. Legally, therefore, malice denotes intent to take life without *legal* justification or excuse. "Aforethought" denotes that "the state of mind imported by malice . . . preceded or coexisted with the act by which death was caused." (4) By the legal definition, malice was present in what Miss A did. She entertained an actual intent to cause death and did an act in furtherance of that intent. She has committed not manslaughter but murder.

Mr. Layman: But aren't there several degrees of murder, not all punishable by death or life imprisonment? Why do you say that this is murder in the first degree?

Mr. Lawyer: The legislature of Maryland has enacted a law which provides,

> "All murder which shall be perpetrated by means of poison, lying in wait, or by any kind of wilful, deliberate and premeditated killing shall be murder in the first degree." (5)

"Wilful" means that there must be a specific purpose and design to kill. "Deliberate" means there must be a full and conscious knowledge of the purpose to do so. "Premeditated" means that the design must precede the killing by an appreciable length of time, "time enough to deliberate." (6) Miss A placed the narcotic within the reach of her brother so he could take it and die, so her act was "wilful." It was obviously "deliberate" and "premeditated" and we are not even concerned in our example with the niceties of what lapse of time is necessary for premeditation. So Miss A has not only committed murder but murder in the first degree, even exclusive of the consideration that the narcotic may be a poison within the meaning of the act of the legislature and therefore murder in the first degree, regardless of wilfulness, deliberation and premeditation.

Mr. Layman: Well, I will assume that what Miss A did meets the legal requirements of murder in the first degree, but there are certainly extenuating circumstances in her case. Mr. A was incurably ill; his death was only a question of time. What Miss A did may have hastened his death but isn't that entirely different from the case where a person by a felonious act kills an individual in good health with no reasonable expectation of dying in the immediate future?

Mr. Lawyer: Of course, death is inevitable for every individual. Where can you draw the line? Should, for example, proof that the deceased would have died from other causes in ten days mitigate the criminal responsibility for the act causing death? Or should it be two weeks, or a month or six months? Or perhaps, five years? The law is clear.

> "Liability attaches if one inflicts an injury from which death would not have taken place when it did, though other causes may have intervened and contributed. One who causes bodily injury to another laboring under a disorder, disease or bodily infirmity, and thereby hastens or accelerates the death of that other, is deemed to have caused his death." (7)

Mr. Layman: We have more than that in your example. Mr. A requested that his sister kill him and consented to the act. What part does his consent to his death play in her responsibility?

Mr. Lawyer:

> "The life of a human being cannot lawfully be taken by himself or by another with his consent. A person who intentionally takes his own life or that of another at the latter's desire or instance is guilty of murder. . . . It is no defense to a criminal charge that an individual directly injured authorized, or contributed to, the infliction of the injury . . . that the injured person ratified or condoned the act of the accused." (8)
>
> "If the doing of a particular act is a crime regardless of the consent of anyone, consent is obviously no excuse. It follows, therefore, that consent of the deceased is no defense, in a prosecution for homicide. The right to life and personal security is not only sacred in the estimation of the common law, but it is also inalienable." (9)

In a case reviewed by the appeal court in Virginia in 1946, a wife threatened to kill her husband. He went upstairs, got a gun, brought it down, handed it to her, showed her how to load it and gave her some bullets. She loaded the gun, shot and killed him. The Court, affirming a conviction of murder, said,

> "Invitation and consent to the perpetration of a crime does not constitute defenses, adequate excuses or provocations." (10)

In a case at the turn of the century in Tennessee, a man was convicted of murder in the first degree for the unlawful killing of a woman and sentenced to hang. The evidence showed that the defendant and the woman had agreed to die together, that the defendant was to kill her and then himself. He shot her pursuant to their agreement, and she said twice more, "Shoot me again" indicating the spot on her body where he was to shoot her, and he did, twice more. She died but he was not successful in killing himself. The evidence at the trial did not show inimical feelings nor motive except in pursuance of the compact for mutual self destruction. The Judge said, in upholding the verdict,

> "The fact that the woman consented and the crime was in execution of a joint agreement, would not remove the case from this grade (first degree) of felonious homicide, since the crime embraced all the elements of malice, deliberation and premeditation necessary to constitute murder in the first degree. . . . Murder is no less murder because the homicide is committed at the desire of the victim. He who kills another upon his desire and command is, in the judgment of the law, as much a murderer as if he had done it merely of his own head . . . Mr. Wharton in his work on Homicide 3rd Edition, section 54 states the rule thus, 'The law does not require that a homicide shall be committed against the will of the person killed. If a man kills another with his consent or by his desire he is as guilty as if he had killed him against his will . . . and the act of a woman swallowing poison in the presence and by the direction of a man renders his the act of administering it, constituting it murder in the first degree where death results.' " (11)

Mr. Layman: But all that still does not take into consideration the motive from what Miss A did. She was not motivated by revenge or ill will or financial gain or passion. Her act is altogether different than a killing during a holdup or because of a real or fancied wrong. She, in your example, acted only by what she thought were the best of motives. She did what she did to keep her brother from suffering further and for love of her brother.

Mr. Lawyer: What you say is true. However, motive and intent are separate and distinct. It is necessary in every crime that a criminal intent be present, often inferred from the act committed, but there is a material difference between intent and motive.

> "Criminal motive is the inducement, existing in the minds of persons, which causes them first to intend and afterwards to commit crime. . . . In the abstract, it might be said that it is unnecessary." (12)
>
> "Motive is immaterial in an involuntary homicide case. The motive of one charged with and being prosecuted for murder need not be established." (13)
>
> "Wrongful motive is not essential to criminality. If one acts or omits to act under circumstances otherwise bringing his conduct within the definition of a crime he is not excused or justified because he was impelled by a good or innocent motive e.g. a sense of right, a religious conviction of duty, a desire to benefit others." (14)
>
> " . . . where the strict legal rights of the people have been pressed, the courts have held that the fact that the killing was to relieve one of suffering, present or prospective, or from other humanitarian motives, neither excuses the killing nor mitigates the offense. The fact that the motive of the slayer is unselfish or according to moral standards, what may be termed 'good', is not ordinarily recognized as a defense." (15)

Mr. Layman: But Miss A's brother himself took the drug that caused his death. She didn't kill him, did she? He committed suicide.

Mr. Lawyer: Remember that in the example the sister provided the drug and remained in the room while he took it. "One who persuades another to kill himself is guilty of murder." (16) It therefore follows that the placing of the means of death within the control of the deceased falls within the rule. In 1920 in Michigan, it was held that a husband who at the request of his wife, who was incurably afflicted with and practically helpless from "multiple sclerosis" mixed poison and placed it within her reach so that she could commit suicide, which she did by drinking it, was guilty of murder by poison under a statute providing that "all murder perpetrated by means of poison" was murder in the first degree. The Court said,

> "We are of the opinion that, when defendant mixed the Paris Green with water and placed it within the reach of his wife to enable her to put an end to her suffering by putting an end to her life, he was guilty of murder by means of poison within the meaning of the statute, even though she requested him to do so. By this act he deliberately placed within her reach the means of taking her own life, which she could have obtained in no other way by reason of her helpless condition." (17)

It is true that under the strict common law if Miss A had left the room and then her brother took the poison, she in all probability could have been held only as an accessory before the fact. Then since the principal, that is the brother, was dead and could not be convicted, she could not be convicted either, because the accessory before the fact cannot be convicted without the prior conviction of the principal. It could just as well be held, however, that she is also a principal. The point was not raised in the Michigan case. No matter how you personally feel about Miss A and whether or not she was morally right or justified, the law holds that she is guilty of murder in the first degree.

Mr. Layman: It seems to me that you have been very technical in your approach to this subject. Do you really think that in a bona fide case of euthanasia or "mercy killing" as it is popularly called, there could be a criminal prosecution and conviction?

Mr. Lawyer: One of the authorities said, some years ago,

> "Publicists have considered somewhat the question whether life may not be taken, with the consent of its possessor, to relieve pain and suffering or other great calamity; but the courts have had to concern themselves very little with such considerations. In the practical operation of the law this question will rarely if ever arise. When the act which immediately produces death is meritorious in character, prosecuting officers will hardly make it a foundation for criminal prosecution." (18)

I strongly disagree with this statement. In the first place prosecuting officers have made such acts the foundation of criminal prosecution, both before and after that statement. In the second place, the prosecuting officer is sworn to uphold the law and if the law has been violated it is his duty to place the facts before the proper authorities, for example the Grand Jury in this State. In the third place, the statement places the prosecuting officer in the position of a judge and jury which is entirely foreign to our conception of the administration of justice. It is not up to the prosecuting officer to determine whether, when the law has been violated, the act was "meritorious in character." That is a judicial function. In the fourth place those who advocate euthanasia are seriously concerned with its legal aspects, particularly with respect to criminal responsibility as shown by the fact that legislation has been proposed both in the United States and England to make euthanasia legal.

There have been a number of cases prosecuted. In 1823 in New York a man named Kirby drowned his two small children because he thought "it better for them to go into eternity than to stop in this world." A criminal prosecution was brought and the trial court charged the Jury that if they were satisfied the prisoner was in perfect possession of his mental faculties he was guilty of murder, although he had no express malice against the children; that is he intended to destroy himself (as he testified he did) and drowned the children to prevent their coming to want, the law implied malice from the illegality of the act; and that every wilful and intentional taking of the life of a human being, without a justifiable cause, is murder, if done with deliberation and not in the heat of passion. The jury returned a verdict of murder (19).

In an English case in 1915 a soldier while home on leave to see his small child, who was very sick and not expected to live, learned that his wife had been neglecting the house and the child and bringing soldiers home at night. He killed the child by cutting its throat, because, as he stated, he "could not see it suffer any more than what it really had done. She (the mother) was not looking after the child, and it was lying there from morning to night, and no one to look after it, and I could not see it suffer any longer and have to go away and leave it." The higher court held that the judge correctly charged the jury that if it found the soldier intended to kill the child, the offense was murder, and that they were not at liberty to find a verdict of manslaughter, though the soldier killed the child with the best and kindest motive. The verdict of murder was upheld (20).

In a case tried in New Jersey in 1922, it was held that,

> "A man (unless not sufficiently sane to know the quality and nature of his act or that it was wrong) who kills his seven year old child to save it from anticipated future suffering and unhappiness is guilty of murder in the first degree if the killing be wilful, premeditated and deliberate, although actuated only by motives of pure, even if mistaken, love and kindness."

In its opinion the Court said,

> "Proof of motive is not an essential element in the conviction of murder in the first degree if the proved facts established that the defendant in fact did the killing wilfully, that is, with the intent to kill and as a result of premeditation and deliberation, thereby implying preconsideration and determination, there is murder in the first degree, no matter what the defendant's motives may have been and although he in fact had no motive (using the word in its usual sense of self-serving reason) whatsoever. Suppose, for instance that this defendant, out of work as he was and unable to support with the cost of necessities of life and three children, with whom he was not living at the time, had conceived the thought that the burdens, the suffering and disappointments of life overbalance its benefits, its happiness and its successes and that he could be doing a kindness to his little boy by destroying the latter's life and thereby saving him from future suffering and unhappiness, and that having given this idea careful and thorough consideration, defendant finally arrived at the determination to kill the child and thereupon with that intent he did kill him in the manner proved and admitted in this case, the defendant was just as much guilty of murder in the first degree as if his purpose was . . . to destroy his wife and children so that their support would not be a burden on him. This is so because the state has a deep interest and concern in the preservation of life of each of its citizens and (except in the case of self defense) does not either commit or permit to any individual no matter how kindly the motive, either the right or the privilege of destroying such a life, except in punishment for crime and in the manner prescribed by law. So strong is this concern of the State that it does not even permit a man to take his own life, but punishes him for an attempt to do so. Obviously if he may not lawfully take his own life even for the best of reasons as they appear to him, there is infinitely more reason why he should not, for like reasons, be permitted to take the life of another."

The verdict of the jury was murder in the first degree with no recommendation of life imprisonment. The verdict was affirmed on appeal (21).

In the Chicago Sunday Tribune of December 2, 1934 a case was reported that was tried in England. A sixty-two year old mother, after thirty years nursing her imbecile son, learned that she faced an operation that might take her life, leaving no one to care for the son. She gave him one hundred sleeping pills and turned on the gas. It was testified that she feared her son, left alone, would suffer what a physician called a "veritable living death." Her counsel is reported to have pleaded that she showed no hate, only undying devotion, and asked the jury "to arrest the law a little, do a little wrong in order to do the greater good." The jury returned a verdit of guilty with a recommendation of mercy. When the defendant was asked if she wished to address the Court she said that she did it in mercy. The Judge, in passing sentence said,

> "We have to take the law as it is, always remembering that in other, higher hands, mercy may be extended. No person in this country has the right to take the life of another human being because she or he thinks it would be better for him to die."

She was sentenced to be hanged.

There was the case of the doctor in one of the New England States who was prosecuted in the early part of 1950 for what the newspapers termed a "mercy killing" of one of his patients. He was found not guilty, and as the case was not reported and no appeal taken, I am unable to ascertain whether the issue before the jury was a clear cut one of euthanasia or whether other factors such as the actual cause of death played a decisive part in the verdict. The fact remains, however, that he was prosecuted for murder in the first degree.

In the Washington Times Herald of March 14, 1952 there was a dispatch concerning a case tried in Eindhoven, The Netherlands. A doctor put his pain-racked tubercular brother out of his misery two years before the trial. He testified that he was convinced that the drugs being given to his brother by the sanitarium were inadequate to deaden the pain and he gave him pills of codeine and then injected sixty milligrams of morphine. The brother relaxed, fell into a deep sleep and died within an hour. The doctor went to the police and told them what happened. He said the brother pleaded with him to end his torture. He said, "I did not take his life—his existence no longer deserved the name of life. I only shortened his suffering. I could not refuse his last wish." He was tried and received a one-year suspended sentence. The article noted that "his trial and sentence had not altered his status as a doctor and his practice. He is popular among his medical colleagues, though few of them agree with his views on mercy." It stated that his practice increased 30% since his confession in 1950.

Mr. Layman: You mentioned that there has been legislation proposed to legalize euthanasia. What form has this legislation taken?

Mr. Lawyer: The Euthanasia Society of America made public the provisions of a bill in 1939 to be presented in New York for the legalizing of mercy killing. There were apparently a procedure established and a competent board to certify incurables. There is no legislative record to show that this bill was ever introduced (22). The American proposals would give the physicians the legal privilege of putting painlessly out of their sufferings not only those in articulo mortis but also the hopelessly insane and feebleminded, the incurably ill and defective infants. There would be professional and legal safeguards against abuse. The consent of the patient would be obtained when the patient is an adult and rational (23).

In England a bill has been proposed for the legalization of euthanasia. This bill is more limited in its scope than the usual American proposals. An application must be made by the person who desires to receive euthanasia. This application states that the applicant has been informed that he is suffering from a fatal and incurable illness and that his death is likely to be protracted and painful. He states that he desires to be killed, that his affairs are in order, that his relatives have been informed and that he knows of no reason why he should not be granted a permit to be killed. The application must be supported by two medical certificates and attested before a designated official. It is sent to an official termed the euthanasia referee, who examines the papers, and interviews the applicant, his relatives and friends and the doctors. If satisfied, the euthanasia referee certifies that the case is a proper one to be granted a permit. The application and certificates are sent to a court of summary jurisdiction sitting in camera. The referee is present and the relatives may attend. The court considers the matter and if satisfied issues two permits—one to the applicant to receive euthanasia and the other to a doctor, who has been licensed for the purpose, to administer euthanasia. The permit is valid for a specified time and then lapses but can be renewed. If the applicant decides to act on the permit he sends for the doctor and arranges dates and details. Regulations for administering euthanasia are made by the Minister of Health. There must be witnesses specially designated when the act of euthanasia is performed. The suggested act provides that insurance companies would be allowed to deduct a small discount when death is anticipated by euthanasia and also grants legal protection to the doctor administering euthanasia and those in any way assisting (24).

Such a bill was introduced in the House of Lords in 1936 by Britain's Euthanasia Legalization Society and after a day's debate was postponed by a 35–14 vote. It had not been revived in 1938 (25).

It seems clear, Mr. Layman, that the person who administers euthanasia or, more popularly, performs an act of mercy killing under the present status of the law, has committed the crime of murder in the first degree, be he doctor, relative or friend. These attempts to legalize such an act support this view.

Mr. Layman: Assuming that you are correct, let us approach the question in an even more practical manner. Do you feel that a person performing euthanasia, in the purest sense of the word, would be convicted if prosecuted?

Mr. Lawyer: Of course it is impossible to ascertain what a court or jury will do in any particular case. You do have a past history of convictions and some recent acquittals. In Maryland the jury in a criminal case is the judge not only of the facts as in a civil case, but also of the law. That is, it is in their province to determine what they consider the law in a given case. The Court of Appeals has said, however,

> "When sworn upon the panel it becomes their duty to decide the case according to the established rules of law of the State and not according to any capricious rules of their own; and it must be presumed that they are always desirous of performing their duty and making their verdicts conform to law." (26)

However they have the power to determine what the criminal law is and apply it to the evidence produced before them in the trial of the case. Such instructions as to the law that the judge may give them are purely advisory and they are so informed by the judge. A jury in a criminal case in Maryland in effect changed the law as to legal insanity and responsibility for crime very recently. But their decision is only with respect to that case and is not binding on future cases embodying the same issues. Another jury may well follow the established law. Also, there is to all practical purposes, no appeal by the State in a criminal case and on a verdict of not guilty or on the absence of appeal by the defendant, there can be no higher determination of the issues. But for a person who may believe that euthanasia is morally and ethically right to commit such an act with the hope that a jury will, as the English lawyer requested, "arrest the law a little, do a little wrong in order to do a greater good" and thereby win an acquittal is patently absurd. It is, aside from its legal aspects, a most controversial subject.

The fact remains that euthanasia, at the present time, is a crime; those performing it are liable to prosecution for murder in the first degree and of the cases that have been prosecuted there have been verdicts of guilty.

BIBLIOGRAPHY

1. Annotated Code of Maryland, Flack, 1939, Art. 27, sect. 481
2. State v. Moore, 25 Iowa 128
3. Wharton, Homicide, 3rd Ed., section 116
4. Laws of Crimes & Criminal Procedure, Hochheimer, Ed. 1904, sections 656–676
5. Annotated Code of Maryland, Flack, 1939, Art. 27, sect. 475
6. Laws of Crimes & Criminal Procedure, Hochheimer, Ed. 1904, sections 656–676
7. Hochheimer, supra, sect. 659
8. Hochheimer, supra, sect. 677 and 25. See also 13 RCL 734 (1916)
9. 26 Am Jur, Homicide, sect. 103
10. Martin v. Commonwealth, 184 Va 1009, 37 SE 43
11. Turner v. State, 119 Tenn 663, 108 SW 1139
12. Wharton's Criminal Evidence, 12th Ed. vol. 1, sect. 246, p. 288
13. Underhill, Criminal Evidence, 4th Ed. sect. 557
14. Hochheimer, supra, sect. 19
15. 26 Am Jur, Homicide, sect. 104. See also 25 ALR 1007
16. Hochheimer, supra, sect. 677
17. People v. Roberts 211 Mich 187, 178 NW 690
18. 13 RCL 734
19. People v. Kirby, 2 Park Crim Rep (NY) 28
20. Rex v. Simpson, 84 LJKBNS (Eng) 1893
21. State v. Ehlers, 98 NJL 236, 119 Atl 15
22. The Commonwealth, vol. 29, No. 16, Feb. 10, 1939, p. 422–423
23. Reader's Digest, vol. 33, No. 199, Nov. 1938, p. 94–98

24. Fortnightly Review, vol. 136, pt. 2, p. 708–718
Law Times, vol. 182, No. 4887, Nov. 28, 1936, p. 412–413
The Survey, vol. 68, No. 8, July 15, 1932, p. 322–323
25. Newsweek, vol. 11, Jan. 31, 1938, p. 26–27
26. Beard v. State, 71 MD 275, 280

MR. STANLEY: Thank you very much, Mr. Orth.

The second subject, "The Sanctity of Life," will be presented by Professor Boas, of the Department of Philosophy of The Johns Hopkins University.

Dr. George Boas.

THE SANCTITY OF LIFE

GEORGE BOAS, PH.D., LL.D.[4]

Mr. Chairman, Ladies and Gentlemen, the reason why I am talking about the Sanctity of Life, and the history of that concept, is clearly because the law as it stands and as it is presented by Mr. Orth forbids euthanasia, as it forbids murder, on the ground that life is sacred.

Now, in primitive societies, as you all know, life is far from being sacred. In fact, one of the things that the gods enjoy is the sacrificing of babies and the sacrificing of maidens. And human sacrifice is one of those things practiced on a grand scale by many primitive tribes.

There are in fact cases even in Greek literature, in the case of Iphigenia, and in the Bible, in the Old Testament, in the case of Isaac, of human sacrifice, which show that in those times at any rate our present conception, that is, the law as it is in its present conception of the sanctity of life, was not entertained by all people. And if you go to Greek times you find that the Greek law permitted the exposure of infants, not merely infants who were defective mentally, or who were crippled, or who were monsters, but any infant you did not want to have around, and it was perfectly well thought of to expose children who were superfluous, or of the wrong sex, or for some other reason. And not only did you have power over infants, that is, the father had power over infants, but you had the power of life and death over your slaves, whose lives were far from being sacred—nobody thought that a slave's life was as valuable as the life of a free man—and when you turn to the Romans, you will find that they continued many of the Greek traditions. You will find that there the same rights which Greek fathers had over their children were enjoyed by the Roman fathers, and in fact to a greater degree. The Roman father could condemn and execute even his adult children. He never did give up that right through the Republic. Those were the inherent rights of any adult male who was the father of a child in Rome. Furthermore, of course, Rome and Greece behaved towards some people exactly as we do today, and whatever may have been the ideas about the sanctity of life in the case of felons or your enemies, or other people for whom you had but the slightest esteem, you put them out of their misery as quickly as possible.

Now, this situation was modified, of course, by the Stoics in Rome. And there is no question about it that Stoicism, which preceded the introduction of Christianity into the Western World, was one of the great influences towards humanitarian ideas.

The Stoics were those people who first of all reduced national boundaries to insignificance, maintaining that the distinction between Greek and Barbarian, between Roman and non-Roman, were insignificant distinctions, and furthermore, as many of you know, they reduced the distinctions between freeman and slave to insignificance. But the Stoics unfortunately were simple philosophers, and their influence over groups of people was just about the same influence that any of us who write books would have.

---

[4] Professor of the History of Philosophy, The Johns Hopkins University.

There was, however, one group of philosophers in Greece who evidently had the most extraordinary influence in the matter of the sanctity of life, and that was a group of people, of whom we know very little, called Pythagoreans. In their philosophy, they taught reincarnation; that after your life on this earth you passed into another existence, either in the form of a superior being, or, of course, as would be the case with most of us, in the form of an inferior being, but inferior or superior, your reincarnation depended upon your virtues in this life. And, clearly, therefore, the number of animals inhabited by previous human souls was always on the increase.

Now, the Pythagorean philosophers actually did maintain that life in itself was sacred. They had a conception of life as something distinct, as you can see, from the body, a very, very curious idea, very much like the original conception of the soul as some sort of gaseous substance within the body.

When you read Pythagorean treatises dealing with this subject, you find that they seem to think of life as some sort of fluid which was contained within the body, and that is why in the Hippocratic oath, which, as you know, of course, is still taken I suppose by physicians even to this day, but how seriously they take it I cannot imagine, in view of some of the things said in it—in the Hippocratic oath, it says, "I will neither give a deadly drug to anyone if asked for it, nor will I make a suggestion of this fact." And that takes care of Miss A, Mr. Orth. Miss A, not being a physician, therefore did not take the Hippocratic oath.

And then it goes on to say that he will not give an abortive remedy, and it says, "With purity and with holiness I will pass my life and practice my art." I say that this is a very extraordinary oath, especially when you realize that medical students, at least in my youth, were required to take it, and it goes on to say, "I will not use the knife, not even on sufferers from stone, but will leave it with such men as are engaged in this work."

Whether that is a simple distinction between the physician and the surgeon, I am not enough of an historian to say.

Our present conceptions of the sanctity of life are derivative from Pythagoras and his school. And that is as far as the doctors are concerned. But in general, as far as the rest of us are concerned, it derives from the Hebrew-Christian tradition as handed down in the Old and the New Testaments, the writings of the fathers, and the works of the philosophers of the Middle Ages.

This is supposedly based, according to the documents which I have seen against euthanasia, on the Sixth or the Fifth Commandment, depending on how you number them, namely, "Thou shalt not kill."

Now, let me say in a footnote that the last time I referred to this Commandment, it was pointed out to me that that is not the correct translation of the Hebrew. I have not the slightest idea whether it is or not. What I was told was that strictly speaking, one should translate "Thou shalt not murder," which, of course, is not the Commandment as any of us learned it, at any rate in English. Whatever the Commandment actually means, most of us take it to mean that you are not supposed to kill. And we know what killing is. And, in fact, many of the tragic dilemmas which conscientious objectors in time of war find themselves in, is due to that interpretation of the Commandment.

In spite of this fact, and in spite of the compulsion or provision of this Commandment, it does not say thou shalt not kill except in certain cases—in spite of that, in Deuteronomy, you are told that certain people are to be killed, namely, witches. "Thou shalt not suffer witches to live, but they are to be stoned to death." And that was a commandment not only taken from Deuteronomy, but you will see that it was put into practice, as you know, not merely in the Middle Ages, but actually in the Massachusetts Bay Colony, in Salem. Think of the thousands of women who were not only killed as witches, but who probably were convinced that they were witches, and who gave the most detailed descriptions of the Witches Sabbath, and how they took off on a broomstick on Saturday night. The thing is perfectly fantastic.

The Bible is authority in the first place for the statement that we are not supposed to kill or murder, whatever the proper translation is, and in the second place that certain people are to be killed, namely, witches. Furthermore, my recollection of the Old Testament is that a great many people actually were killed throughout the narrative or historic portion of the Old Testament. The Jews and the Philistines were constantly at war, and the Old Testament is a steady record of one kind of warfare or another kind of warfare. And I find that it was agreed to by a great number of people, and they permitted the amount of slaughter that actually went on, as recorded in those times.

None of those people after all paid the slightest attention to the Sixth Commandment, as far as I know. But not only that, when you come down to Christian times, none of us have forgotten the Institution of the Inquisition, in which heretics were not only ordered to be killed, but were killed.

Now, a heretic presumably is a human being, and consequently has life, but, nevertheless, a heretic is supposed not to have a sacred kind of life, so that you have to admit that in both Hebrew times and Christian times, that is, through the Middle Ages, in spite of the fact that the theory was that life was sacred, the practice was that it was not sacred except under certain conditions.

You will find exactly the same thing to be true in Anglo-Saxon times in England. According to the common law, as Mr. Orth, I think, would point out, there were degrees of sanctity, degrees of sanctity which no longer, of course, would obtain, but which were clearly indicated in the law of the times, in the amount of money a person would have to pay if he actually killed somebody, the Wergeld, or the amount of money you paid the family of the person you killed. And if you killed a slave, you paid less than the amount that you paid if you killed a lord. And there is the difference of degree in the value of the life that you took.

When we come to our own times, we know that in spite of this talk about the sanctity of life, our practice, nevertheless, is that many lives are not sacred at all.

As Mr. Orth has said, certain felons are to be killed. And in fact the irony of the situation in the case of Miss A and this woman in England, sixty years old, who had for thirty years taken care of her imbecile brother, and then gave him the preparation which put him out of his misery—the irony of it is this, that life is sacred and she must not take it, but, nevertheless, the state takes her life.

It is a very curious situation, you must admit, and I have no doubt that a lawyer could explain it to the satisfaction of you people, but I must admit that a philosopher thinks it is very hard to explain.

There is no need of my listing the number of crimes which are punishable by capital punishment. Treason is supposed to be. But we have never so far as I know executed anyone for treason. Desertion in the face of the enemy is a capital offense, according to the law of courts martial. When you kill somebody in self-defense, the person whom you have killed does not have a sacred life. Of course, in the case that Mr. Orth mentioned of the degrees of homicide, after all, the result of your act is precisely the same if you are dealing with a case of manslaughter as it is if you are dealing with a case of murder in the first degree. In other words, the man is dead. Whether you run over him with an automobile or whether you actually stick a knife into his heart or shoot him, poison him or anything else, as far as he is concerned the results are precisely the same, and his life is no less sacred because you did not intend to take it.

So that there seems to be in all of these countries which I have mentioned, and in all of these cultures and civilizations, a sharp distinction between the kind of life which is approved and the kind of life which is not approved, and those lives which are approved, or the kind of life which is approved, are sacred and you are not allowed to take them, even if the life is your own, but the kind of life which is not approved you are allowed to take, and in fact at times you are ordered to take it, namely, in the case of warfare.

In a situation of this sort, as you look at it from the aloofness of a professor of philosophy who has nothing but the kindest regards for the rest of the human race—I suppose when you approach a certain age and you think of yourself as a possible subject of euthanasia, you get more philosophical and more kind—in any event, to come back to my point, you will observe that in all of these cases the state acts as a punitive agent, not as a preventive agent. It does not act as a preventive agent in any sense of the word. The courts may say that they regard life so highly that they do not even allow a man to commit suicide, as the Romans and Greeks did, but on the other hand, they do not do anything to improve the quality of life or to make life any more valuable for the people who are actually living it.

Now, the form of the punitive aspects of the state's attitude towards life is a very simple thing to understand. It comes under the police power. The state is supposed to protect our lives in the sense of punishing people who take them, just as it is supposed to protect our property, in the sense of punishing people who steal it. But heaven forbid that the state should do anything to improve the quality of our life. If it did, you can imagine the editorials that would be written about the Welfare State.

Of course, strictly speaking, if you were really against the Welfare State, as I gather some of the best people are, there should not be any hospitals for the public, and there should not be any public schools, and God forbid, there should not be any sewerage system, for all of those things come under the head of common welfare.

Well, the conclusion of all of this is clearly that in spite of everything that people have said about the sanctity of life, nobody has really taken it seriously, nobody, as far as organized society is concerned, has really applied this in any general way at all. And when I say nobody, I mean not only the state, but also the churches. The Church itself has not taken this seriously. When it turned over to the secular arm the punishing of heretics, clearly it did not think that those heretics had a sacred life. Far from it.

The conclusion, therefore, is that the state is very selfish about it, that it wants to take life, and it will give certain people the right to take it, but it won't permit individuals to take life. And that is really what it comes down to.

MR. STANLEY: Thank you, Dr. Boas.

The medical aspects relating to this subject will be presented by Dr. Louis Krause, Professor of Clinical Medicine at the University of Maryland. Dr. Krause.

MEDICAL ASPECTS RELATING TO EUTHANASIA

LOUIS KRAUSE, M.D.[5]

Thank you very much, Mr. Stanley.

"Thou Shalt Not Kill." Did you ever stop to think, those of you who are familiar with the earlier Judeo-Christian ethics, who it was who said that? That was first said by a man who killed someone. It is curious, isn't it? I wonder what mental processes went through his mind after he killed an Egyptian, was detected, then

[5] Professor of Clinical Medicine, University of Maryland School of Medicine.

fled the just trial that he deserved, went into Sinai, remained there until the Prosecuting Attorney or the Pharoah, died, and then returned. That man was Moses.

He not only did that, but he threatened even another Egyptian before he went away into Sinai. And I have traveled that road twice and have gone up to that mountain of the Decalogue, where he received the Ten Commandments. And I have wondered many times what the source of that was, and what did Moses learn from that great priest, Jethro in Sinai, who probably belonged to the Minean culture, of which we know so little. And Moses himself, who enunciated this in our so-called Ten Commandments, was far from being an obedient servant of God in many ways. He questioned Him. He had no complete confidence himself of the times. He wanted reassurances over and over again. And he became so indignant at one time that he said to God, "Take my name from out of your Book." And it is from him that we get our Commandments.

Do we hold it sacred? Maybe society does not, but I want to present this to you, that in spite of the fact that there are differences of opinion with people on this, that we in medicine, I think, by far surpass every other group in considering life sacred.

It is interesting that it was not always sacred in ancient days, as you have heard from Dr. Boas. The life of a slave was never as sacred as the life of a freeman. Look in your Old Testament. Bodily injuries were worth much less in slaves than in freemen. One often hears the argument by the so-called Orthodox believers that to interfere with life, particularly in shortening it, is contrary to the will of God.

Let us look at that more carefully. Every day in medicine someone comes to a doctor with a disease that is reversible, or that can be stopped in its tracks.

I recall one person who was very insistent that we had no right to interfere with the will of God. Of course, that is true. Who denies it? But do we put that into practice? A patient comes to us today with pneumonia, and we know that 94 per cent of pneumonia cases can be cured. When that patient comes to me, or to any doctor for treatment, and he receives some medicine that cures him, am I interfering with the will of God? How do I know that it was not the intention of God that this patient should die of pneumonia? Did I interfere with that process? That is just as much interfering as taking a positive action. But we don't hesitate to give that patient the appropriate specific drug and stop the disease. So I think the Orthodox from their Scriptures cannot offer any argument one way or the other on that score.

There are five suicides mentioned in the Old Testament. Samson pulled down the pillars of the Temple in which he killed the Philistines and himself. He was accorded a proper burial, and no criticisms made.

Saul asked his armor-bearer to run him through with a sword. His armor-bearer was afraid and refused to do it. Saul then killed himself. And his armor-bearer, in turn, killed himself.

Ahithophel, after a battle, seeing that the people did not follow his orders, went to his home, or the palace, and set it afire and destroyed himself.

Zimri, seeing the loss of his folks, went back to his house and hanged himself.

Five cases of suicide. The Bible is silent on suicide, which to me is murder, as is the interpretation that Mr. Orth gave.

We try to understand the processes that may lead to suicide. We can treat those patients and bring them out of a depression, that until recently we could not do.

The one questionable case in the New Testament we have to suspend our judgment on, is Judas. We have one statement that he hanged himself, and another that he fell down and struck the rocks and was in a pool of blood, and his bowels gushed forth. So we don't know. We cannot pass judgment on that. But the total

Scriptures, the basis of our Judean Christianity, are without comment on that kind of matter. And then, from the traditional point of view, we have a long story on it in the Catholic Church, or the Christian Church, and before the days of the Reformation. We have many of those in that group that had varying ideas of physiology, of course. In those early days, they asked when was the soul introduced into the body of the unborn child. It was only when the soul was pictured as being in the body that to do something then to the unborn child was murder. Before, it was not.

But don't you see that physiology, and science, and such things are way ahead of the conservatism of religion? The great English scholar, Sir Thomas More, in his Utopia, clearly supports the thesis that in an incurable and painful condition, the patient is justified in asking an escape.

I have pursued this story of the Biblical side of the picture not only particularly on that angle, but on other ones, in the East, in the Biblical lands, and particularly in Palestine and in Egypt. I am very convinced that the average member of any of the institutions professing the Judeo-Christian ethics gives a great deal of lip service, but knows very little about what is contained in the Scriptures as the foundations of their beliefs and traditions.

Critical faculty is not yet fully developed. There has been loosening of reliance on inherited wisdom and tradition, whether in the shape of the Church or in folklore. From the medical point of view and from my interpretations of the Scriptures, I am unhesitatingly a very positive champion for the view that life should be preserved to its ultimate, regardless of the conditions at hand.

Let me go a little further. The mere degree of illness, however extreme, should never be mistaken for the signs of impending death. The inevitability of death in any disease is never more than an estimate passed upon an opinion and experience. How fallacious experience in medicine may be, only those who have had a great deal of experience in it fully recognize. And I fail to see how anyone excepting doctors can really honestly give an opinion, and then they are very willing to admit that they have been wrong so many times that they hesitate to state in any positive way the outcome of any case. I have been wrong many times in prognosis, being unable to evaluate the patient's will to live.

Medicine is eternally dedicated to curing the disease, and failing this, to alleviate it.

And maybe we should go into it a little more, the definition of the term "euthanasia." This is an old term. It comes from the Greek "euthase," meaning well, and "thanatos," meaning death—well, it was used by Cicero. And it has been used many times since. Never in the sense that you took a person's life, but you permitted him to die comfortably.

And I want to stress that a little bit. Many diseases today are reversible that a few years ago were hopeless. Pain and disease are a challenge to the medical profession, and I am sure they will always remain so. Because of that refusal to admit disease is hopeless, progress has been made in curing many. When a patient appears to be hopeless and when the prognosis likewise to the doctor seems dark, frequently the patient that has the indomitable will to live will finally survive in spite of predictions. There should always be a distinction made between prolonging life and prolonging the act of dying. Making imminent inevitable death easy is one thing. This, of course, is many times difficult, but there are occasions in which there is no room for doubt in our present knowledge that death is imminent. Let us assume an individual with a brain grossly macerated in an accident, large substances of it lost, and yet his heart pumping regularly and his respirations still present. We have no hope of replacing good brain tissue within that skull. Suppose you were in that position, what would you do? That is what concerns the doctor.

Another thing which I saw just three or four nights ago—a man with a hopeless malignant disease of his esophagus. He had already lost one hundred and some pounds. He had been unable to swallow for days and days and days. And there was done all that a surgeon could do. He had all the treatments that could be given, sedatives, etc. At two A.M., a call comes while our lawyer friends are in bed, while our clergy are in bed, snug, warm—this man has a severe hemorrhage, which is frequently the mode of exit—he has not much to lose—what would you do at two A.M.? Well, the family answered it. But what would you think of it? What would you do in that position? The man never asked for any exit from this life. With all the drugs that we doctors prescribe, potent ones within his reach in the sick room, I have yet to have a seriously ill patient take an overdose of it. And it is available to him. I question the frequency of such incidents.

What would you do in this incident, in an individual youngster, who is severely burned, so that he has lost all but one third of the skin on his body. We cannot replace skin on that patient from someone else. We can keep him alive by repeated transfusions of plasma, or antibiotics, and so on, but the day is going to come when your transfusions will run out, and where will you get your donors? We have no hope of giving him skin to cover up that part of his denuded body. Death is going to come. You have to make a decision. What would you do?

And I am sure that no one holds the absurd view that God wishes his creatures to suffer pain, and likewise we certainly have no justification of assuming that pain is an atonement for sin, nor that diseases are a result of sin. You know how much that has retarded scientific medicine throughout the centuries, the concept that disease is due to sin. The corollary to that concept is as follows, that to get rid of the sin you have to appease an angry God, or you call in the priest, the representative of that God. You do not look for the pathology, for the poison, for the drug, the ulcer in the stomach, or the stone in the bladder.

It was the Church, or religion, I should say, that violently opposed relieving the pain of childbirth when relief was available, because they took literally and seriously the injunction that woman must bring her child to this world in pain. We don't believe that any more. We don't practice that. It was thought that to suffer was God's purpose. But there again physiology, or let me say medical practice and science, were ahead of the dogma and the doctrines of that day. That is not taught in any medical school today.

And I am well aware of the psychological effect that pain may have in fortifying character in many instances. I have never known of a single physician who in any way has given enough sedative to purposely produce an easy death. And I know a lot of doctors. To the contrary, many times, and in my own experience, I have given an elderly sufferer of continuous pain, being aware that morphine may be a depressant to that old patient's breathing, I have given him frequently too small an amount to relieve his pain, because I was afraid of interfering with life.

At this time I think the medical profession looks upon pain and disease strictly as a challenge. I am confident enough to believe even that the inevitability of old age today at sometime in the future will give way to methods that will prolong life and even delay the aging process. Threescore and ten is the Biblical tradition and one hundred and ten is the ancient Egyptian tradition. And so it depends on what you follow.

There is no justification for society to look upon the doctor as the one who should quietly remove the patient from this life. One must distinguish between the agony of the patient and the agony of his friends and relatives.

Only too frequently do I hear from patients, as I heard today from a very orthodox Christian individual, that once the individual died, they thought it was a blessing. And I hear that over and over again. You offer them the hypodermic to put them out of their misery, and they hesitate. And why should you ask the doctor to do it? The doctor does not do it, and has never done it, as far as I know, and I don't know of any one who will volunteer to do it.

Regardless of how distressed the patient may be from physical pain, I have personally never had the experience of a patient asking to be relieved from life. And, as I said, they had the drugs often within their reach almost constantly.

I have seen elderly patients, not in any physical distress, but because they have lost every living bond with the living welcome something that would carry them to their eternal home.

And let me strongly support Dr. Boas in what he said, that the state does nothing for the living here. Our old-age problem is crying and is begging at our doors. What are you doing about it? The state has done nothing yet that could be positive action.

Public opinion may in the future consent to the destruction of life on compassionate grounds for the monster that is born, and the congenital idiot. But that is society's problem and not the doctor's. And at this time I can say with one hundred per cent assurance that no doctor has done such a thing or is in favor of it. The medical profession is unalterably opposed to those practices today. The Court addresses itself to the end of the process. We are concerned with methods and thoughts. We try to understand people's sins and not to condemn them, not to criticize them or pass judgment.

And if ever such a thing were passed by society, I see no reason why the doctor should be the executioner in that instance.

When the judge passes the death sentence upon a prisoner, does he forthwith proceed to execute that prisoner?

The doctor's field of activity is always in prolonging life. The dissolution of life is entirely out of his reference.

To me, and I am sure it is true of every doctor, death is always ugly, it is a defeat, it is a loss. If you ever had a pet dog that lived many years and became infirm, do you hurry to put it out of its misery. If you do, don't you feel bad afterwards? You wonder whether you did not let him down. And if that is true there, how much more true that would be when I am called to see an aged individual, or suffering, and to go there with the motive of passing him on, that is repulsive and repugnant to me.

It is my feeling, in view of our knowledge today, that the doctor is in the best position to carry on with the patient who is in imminent danger of dying. The good doctor will only be concerned with prolonging that life and prolonging it comfortably. I am most emphatic in my belief that no doctor does knowingly end a life. The good doctors are well aware of the distinction between prolonging life and not prolonging dying. The former is in his reference. The latter never.

The state does give the doctor the right to prescribe drugs that can kill, but it does not regulate dosage. For an untold number of years doctors have been given that trust, and by and large they have not betrayed that trust.

Today, since medicine in my opinion rises above the level of the various religious denominations, the doctor looks upon every man as his brother and as God his father.

That to me is the most glorious thing of medicine, that we accept patients as they are with no criticisms, reservations, or to what group they belong. And how many of us will be disappointed in heaven when we see so many others that have gone there by a different route. I often wonder about it.

The position that I take is so well exemplified in the parable of what happened on the Jericho Road. Now, I am no pietist, but I have been interested in the old Bible lands to the extent of excavating archaeologically in the Near East. And over and over again I have gone down this Jericho Road. It is the place of the parable of the Good Samaritan. And you know that story.

That to me stands head and shoulders above most of the parables. You recall the story of the man beaten and robbed and injured on the wayside. Who passed him by first? A priest, a representative of a formal religion. Who passed him by next? A Levite, another representative of a formal religion. But the third man who came by was a heretic, he was a Samaritan. But there was one thing he possessed, and that was compassion. And that is the doctor's role. And he picked him up, took him to an inn and had him cared for.

And I hope that you, since the last thing you will do is die, I hope at that time when death's cold sullen stream over you rolls that you will have beside you some well-equipped, medically and mentally, good doctor who will be motivated with faith, hope and love.

Mr. Stanley: Thank you, Dr. Krause.

QUESTION AND ANSWER PERIOD

Mr. Stanley: I shall appreciate it very much if Mr. Benjamin Wolfson, Mr. Theodore C. Waters, Jr., and Mr. Daniel B. Leonard will be kind enough to constitute themselves as ushers in their respective tiers of seats and collect any questions which may have been written, and deliver them to the desk here.

While these questions are being collected, I should like to start to submit to the members of the Panel the questions which have been prepared by the Medical-Legal Committee and by the members of the Panel.

The first question is directed to Mr. Orth.

Q. Mr. Orth, the question is, How should one resolve a conflict between the law and morality?

Mr. Orth: I think that perhaps Dr. Boas is much better qualified to answer that question than I am.

In the first place, the question assumes that there is a conflict between the law and morality. And limited to the subject tonight of euthanasia, I am not so sure. If you take morality and define it as the doctrine of life, I don't know whether we are prepared at this time, in this state of our civilization, that one of the doctrines and one of the duties of life is the performance of euthanasia.

If we assume that it is and euthanasia is now proper, then the question is if there is a definite conflict between that morality and the law. And what would you do? Can you change the law?

Now, if we are ready for euthanasia—and it is a crime now to commit euthanasia—and they legalize it, that is the only step to take. But there are certain factors, of course, that even if you consider that it is not a crime to perform euthanasia, perhaps it should be prohibited anyhow, in the public good. The answer to it, I think, is to change the law.

Q. Mr. Stanley: Dr. Krause, has not the progress of medical knowledge been due in part to our stubborn refusal to admit that any disease is incurable?

Dr. Krause: I think that the answer to that is yes, but I don't know whether you always have that motive in mind. I don't think there is any question about that. The answer there would have to be yes.

Q. Mr. Stanley: Dr. Krause, here is another question to you. What percentage of patients at present die under conditions which might be alleviated through euthanasia?

Dr. Krause: Well, if I were to include all the drugs that I see used, I think I would put it around the other way and ask what percentage of patients have been helped with our present modern methods of treatment.

Q. Mr. Stanley: Dr. Boas, of what value is the history of an idea to a person who is pleading for legislative reform?

Dr. Boas: Well, the value of it is in that we can see that we have gone quite a way. And the one thing that is of the greatest importance is to find out how we got to where we are. And I happen to believe that there is a very sharp distinction between law and morality, between me and my neighbor on my left. When we go down to Annapolis to have a law changed, I think it is extremely important to know what historic causes lie behind the pleading.

Now, the law is about three generations behind the public as far as morality is concerned. And consequently only by a study of the history of our moral and legislative ideas can you plead for a legislative reform, in my opinion.

Q. Mr. Stanley: Dr. Boas, is there any religion which does not hold life to be sacred?

Dr. Boas: Yes, Buddhism does not hold life to be sacred. And that is brought out in the history of Buddhism. And nobody can say that the Buddhists are not as intelligent as we Europeans. And by Europeans, I mean Occidentals. Now, here is a religion that believes that life is not sacred at all. And Schopenhauer said that the original sin is being born.

Q. Mr. Stanley: Mr. Orth, the next question is for you. Legislation, though it sometimes expresses ancient traditions, has been changed. For example, the position of women in most Occidental countries. How does such a change come about?

Mr. Orth: Well, from the purely theoretical point of view, under our system of government there is a realization on the part of the public that a change is necessary. Acting through your representative in the Legislature, who also realizes that a change is necessary and that the public desires it, they change the law.

From a practical point of view, however, it may not work that way. It is a slow job. If there is perhaps a minority group that wants the law changed, despite tradition, they work to change the law while the majority is apathetic.

Q. Mr. Stanley: Dr. Krause, has this civilization reached a stage where some form or type of euthanasia under some circumstances should be legally justified?

Dr. Krause: If you mean the civilization that we have here at this present time, I would say no, it is not ready for it, but how much it is going to spread over the globe, the theory of it, I don't know, but if, as Mr. Orth I think stated, a number of people decidedly agree with the theory of euthanasia, then I can see the possibility that such a law may be passed in the not too distant future. But at the present moment I would say that society, as I have dealt with these things, is not ready for it at the present time.

Q. Mr. Stanley: Mr. Orth, is there, at the present time, any legislation, either in this country or abroad, which specifically allows euthanasia or prepares the legal background for the same?

Mr. Orth: Not that I have been able to determine. If it has been approved, I have not found it.

Q. Mr. Stanley: Here is another question, Mr. Orth. Would you include in the category of euthanasia cases where omissions or discontinuances of therapeutic procedures lead to prompt exitus of the patient? For example, the discontinuance of transfusions in the patient with aplastic anemia?

Mr. Orth: Yes, I would. The law states that if there is a duty to act, an omission to act is the same as a positive act. In the example cited, if there was a discontinuance of the efforts to prolong life on the part of the doctor, the doctor knowing that the discontinuance of this effort would result in death, then he is guilty of murder in the first degree.

There is a legal duty on the part of the doctor to perform such acts. It does not extend to the point where there is no legal duty to perform the act. For example, if you saw a man drowning and you were on the pier with a life preserver in your hand, there is no duty for you to throw that preserver, but the doctor is, in fact, under a contract, and it is his duty to prolong life, and if he omits that act, knowing that the omission will result in death, he is guilty of murder.

Q. Dr. Krause: Mr. Stanley, may I ask a question about that?

Mr. Stanley: Yes.

Q. Mr. Krause: How about the cults, for example, the Christian Science groups? They obviously have a number of patients that are admittedly being treated wrong by our present methods.

Mr. Orth: And there have been prosecutions.

Dr. Krause: But they are mighty few.

Mr. Orth: But they are mighty few, I agree with you.

Dr. Krause: But there has been a concerted effort not to do something.

Mr. Orth: That is correct.

Q. Mr. Stanley: Mr. Orth, another question. Would an Act to legalize euthanasia be constitutional in Maryland?

Mr. Orth: I do not see why it could not be. We have on the books at the present time a law making abortion in certain cases legal. For example, if the doctor, after consulting with two or more, or one or more other doctors, and in their respective decisions they determine that the fetus is dead, or that the abortion is necessary, necessary for the health of the woman, then the abortion is legal.

Now, certainly there is no great distinction between such a law and a law which would legalize euthanasia.

From a purely practical point of view, I do not think that the members of the Legislature would want to take the personal responsibility of enacting such a law. They would probably and properly put the question up to the public, and if the public votes for it, I see no reason why it would not be either constitutional or legal, by changing the constitution, or by an Act of the Legislature.

Q. Mr. Stanley: Another question, Mr. Orth. And I am inclined to think that this may have been expressed in one of your other answers, but as it has been submitted, I will give it to you. Would failure of a doctor to take proper steps to save the life of a patient be a crime?

Mr. Orth: I think I have answered that, Mr. Stanley. It is an act of omission, and technically it would be.

Mr. Stanley: There will now follow the questions which have been submitted from the floor.

Q. Dr. Krause, to what extent does the practice of abortion exist in our society and weaken our sense of sanctity of human life?

Do I make that clear, sir?

Dr. Krause: Well, do you mean in hospital practice or in neighborhoods by women?

Mr. Stanley: I understood from reading the question that it meant by doctors or hospitals.

Dr. Krause: I think it is extremely rarely done, or, rather, the patients are fewer and fewer here in hospital practice, but the level is very high in neighborhoods.

Q. Mr. Stanley: Mr. Orth, would a Maryland jury, who in criminal cases are the judges of the law as well as the facts, be likely to convict "Miss A" of murder in the first degree?

Mr. Orth: You ask if it is likely to. I can only say that the polls that were made by the two institutes indicated about a fifty-fifty split. It takes twelve votes to convict. It takes only one vote to hang the jury. If you, as a representative, would get six for and six against, as the public opinion poll indicated, you would not have an acquittal, but you would have a hung jury.

But to ask what a jury would do in a particular case I cannot answer. I would say certainly that there would be a lot of sympathy for Miss A. On the other hand, there would be others—and it is a most controversial subject—who would feel very definitely that to take human life, no matter what the reason, is wrong, whether their reason is based on philosophy or religion, ethics, morals, or what have you.

I would say that you have a good chance. I would rather defend than prosecute.

Q. Mr. Stanley: Dr. Krause, when a patient is hopelessly ill and can no longer be fed by mouth or alimentary tract, what is the doctor's responsibility to prolong life by intravenous feeding?

Dr. Krause: He does it.

Q. Mr. Stanley: Dr. Boas, what are your personal views about euthanasia?

Dr. Boas: Well, of course, I think that here is one of those things where you get a definite conflict between morality and the law. The law says that euthanasia is murder. Morality says that you should not let people suffer unnecessarily.

Here you have a tragic dilemma. And this is not the only one. In your conscientious objector, you have a man who does not believe in murder, so he is up against the law, which tells him to go out and get in the army and learn how to shoot and shoot well. We are constantly faced with that sort of question.

Now, since I am a very soft-hearted person, I should be on the side of the euthanasiasts, if that is the correct word, who would put the poor devil out of his misery, whatever the law says, but I cannot do it, because I would be afraid of the law, if called upon to make the decision.

And this is what I was referring to before. You cannot change the law. I mean you can say yes, you can do it, but the problem is to do what the suffering person wants you to do at that time. Now, we do it to animals after all, and, as I say, all this hypocrisy about the sanctity of life, is a bit sickening; it is the state that we are talking about here, and the church, when you come right down to it, and God makes his views known through human beings, and after all those people have never seriously thought that life was sacred, except when they want to punish people for taking it. But when they want to take it, they take it. And that is the law of Maryland and every place else.

Well, I have talked too long.

Q. Mr. Stanley: Dr. Krause, how do you determine the point at which you cease to prolong life and start to prolong death?

Dr. Krause: I don't know how I can answer that. All we do is try to keep them alive. Even though it looks perfectly hopeless, we try and try and the family frequently say: Well, don't torture them any more, but we still try.

I don't know what the questioner has in mind.

Q. Mr. Stanley: Mr. Orth, can you answer Dr. Boas' question as to how you justify capital punishment and punish in a case of mercy killing?

Mr. Orth: I don't justify it. The law says what will happen.

Of course, the law originally, or not originally but back in former times, was jealous of the life of its individuals, because the loss of such a man, of a freeman, would be the loss of a fighting man for the sovereign. And it can be further carried out, that if you are allowed to kill indiscriminately, you are allowed to kill off the taxpayers.

Q. Mr. Stanley: Dr. Krause, what are the medico-legal aspects of withholding treatment deliberately which might prolong the life of a patient but not cure him?

Dr. Krause: Well, I don't think that is done. It is not withheld. That is the very point made. We still give it. I think that would be just as important as giving him something to kill him.

Q. Mr. Stanley: Dr. Krause, is there any case in which it is justified?

Dr. Krause: I don't know of any.

Q. Mr. Stanley: Dr. Krause, you seem to be very popular from now on, sir. Here is another one. Have you any comment to make relating to the trial of the physician in New England for alleged euthanasia?

Dr. Krause: No. I think that is the trial in which air was supposed to be injected, and then the reasons or the excuses that were given at the trial were reversed afterwards. I think Mr. Orth can tell you about it better than I can.

Mr. Orth: He was found not guilty. Defense counsel argued that there were no legal aspects of euthanasia during the trial. I think that was it.

Q. Mr. Stanley: Dr. Krause, how do you reconcile your statement that you wonder when you attempt to heal the sick that you are working against God's will and the life of Christ? He cured the sick and raised the dead. If you sincerely did the same, short of raising the dead, wouldn't you be following God's will?

Dr. Krause: Yes, I think that is perfectly true, if we did that, if we raised the dead. And don't forget this, that Christ drove demons from individuals. We don't believe that today. I think you have to interpret things in the light of the times in which they were written. He used methods that we are totally unaware of, but they were effective, according to tradition. He did not hesitate to cure people. And he did not say that they should have to continually suffer. And that is my position now. And those people who say you are interfering with life or with God's will when you shorten life, which we do not practice, but, nevertheless, it can be said that we are interfering with processes constantly in disease, which could be interpreted as God's intention that we call so-and-so to their eternal rest, as I heard one individual express it to me.

Mr. Stanley: There has been a suggestion made that we poll the audience upon the question of whether they as members of the jury would vote to convict Miss A. And if there is a substantial feeling that that vote should be by secret ballot, it could be arranged. However, upon the assumption that a secret ballot will not be demanded, I shall ask all of our guests who think the jurymen or jurywomen would vote a verdict of guilty to raise their hands. (Raising of hands.)

Mr. Stanley: I shall ask Mr. Waters, Jr., and Mr. Leonard, if they would be kind enough to count those hands and report the results. (Count made.)

Mr. Stanley: Now, will all those ladies and gentlemen who would vote for a verdict of not guilty raise their hands? (Raising of hands.) (Count made.)

Mr. Stanley: There being 84 votes in favor of not guilty and 38 in favor of a verdict of guilty, Miss A is acquitted by the jury.

Mr. Orth: I will not take that as conclusive, because the ones who voted for guilty may be on the jury.

Q. Mr. Stanley: This is the concluding question, which it has been suggested be submitted to Dr. Boas. Where does all this lead us?

Dr. Boas: Well, Mr. Chairman, I think this leads us to exactly the place where we were before we went into it, namely, that the people were aware of the law, as they have always been, and that legislation comes trailing along, and quite properly so, because after all the Courts have to move in an extremely conservative and cautious fashion.

Of course, this is not a typical audience. There is no question about that. And, furthermore, in some states this audience would have to vote for Miss A as guilty. And there is no question about that either. And that is so because in most states the jury does not make the law.

I should say that this audience, as Mr. Bumble said, thinks that the law is an ass, and is simply cruel and without any thoughts especially for the welfare of individuals.

Of course, you can never settle a question of that sort to everybody's satisfaction. I mean there are opinions and disagreements after public opinion has been drawn into legislation, and many of the laws which are new laws, are laws with which the people do not agree. We have made twenty-two amendments to the Constitution and even they do not meet with universal approval. So that one must always expect a certain amount of disagreement in society.

What I hope is that some of us have succeeded in making you realize that there is (a) a very sharp conflict between the law and public opinion. And I think, although some may not agree with me, that morality, that is, the feelings of morality, goes to the prevention of suffering and (b) a very sharp conflict between the duty of a physician, as Dr. Krause has given it to us, and once again popular sentiment.

I don't think one can say that it has led us any further than that, but after all if we have succeeded this evening in clarifying the issues, making those issues clear-cut, so that the clash in opinion becomes obvious, I should say that we have been led far enough along the road to look for a solution of this problem.

Mr. Stanley: There being no further discussion, the meeting is adjourned.

THE VACCINATION AND IMMUNIZATION HISTORY OF CHILDREN ENTERING FIRST GRADE IN 1951 AND 1952

CHARLES R. HAYMAN, M.D., M.P.H.*

Introduction

Private practitioners and public health physicians will agree that every child should be vaccinated against smallpox, and immunized against diphtheria, pertussis, and tetanus, before reaching the age of one year. The histories of children now in the first and second grades indicate that we have a long way to go before reaching this goal.

This is essentially a problem for private physicians, since the wellbaby clinics serve only the indigent and medically indigent—less than 10% of the 2,000 babies born each year.

Harford County is fairly representative of the counties of Maryland. It has a population of 53,000. One quarter live in three small towns, and the remainder are rural non-farm and farm residents. The Negro population is 10%. There are 29 general practitioners, and no full time pediatricians.

It differs in that it has two military establishments, with an associated dependent population of several thousands, which is shifting rapidly. Another difference is that because of its nearness to the city, much of the medical care is provided by Baltimore physicians and hospitals.

Procedure

This study is a by-product of the preschool examinations done by private physicians in their offices.

At registration for school in the Spring of 1951 and 1952, each parent was advised by a public health nurse to have her child examined by her own doctor. The parent was given a blank medical record to be completed by the physician and returned to the health department. Information as to previous Vaccination and Immunization was obtained by him from the parent or from his own files. Vaccinations and Immunizations done at the time of the examination were likewise entered on the record.

In 1951, there were 1079 children registered for the first grade. 668 or 62% were examined. These were done by 67 different physicians. 26 were civilian physicians in Harford County and 9 were Army physicians at the Aberdeen Proving Ground and the Army Chemical Center. Two were Baltimore pediatricians working in the wellbaby clinics, who examined 40 children. The remaining 30 physicians were mostly in Baltimore City and county, but a few were practitioners in adjacent Cecil County, Maryland and York County, Pennsylvania (1).

In 1952, there were 1427 children registered for the first grade. 1090, or 76.2% were examined. 50 were examined at the wellbaby clinics, and all others by their family doctor.

Findings

First Vaccination—The information given by the physicians showed, that of the children entering school in 1951, only 25% had been vaccinated before their first birthday. After this a smaller percentage was done each year, until at the time of the examination 71% had been vaccinated. 173 were then done, bringing the percentage up to 97.

Of children entering in 1952, 28% had been vaccinated in the first year of life. At the time of examination, 76% had been protected. 221 were then done, bringing the percentage to 96.2.

Re-vaccination—Including those done as part of the preschool examination in 1951, 9% had received a second vaccination. On the other hand, after examination of the 1952 group, 18% had been re-vaccinated (Figure 1).

First immunization against diphtheria, pertussis

---

* Deputy State and County Health Officer, Harford County, Maryland.

and tetanus—The physicians stated that 42% of the children entering school in 1951 had been immunized in the first year of life. 72% had been protected by the time they came for the preschool examination. An additional 111 children were then given their first series of DPT, bringing the percentage protected up to 88.

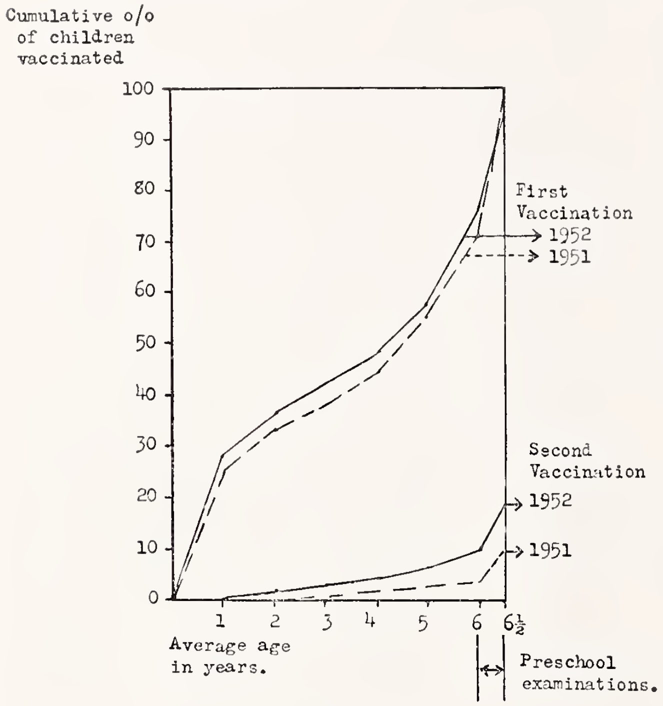


Fig. 1

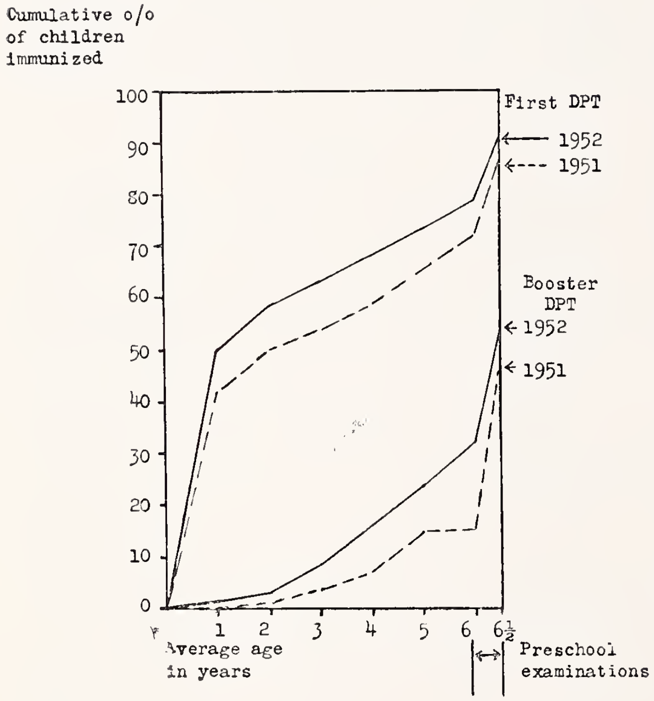


Fig. 2

Of the 1952 entrants, 50% had been immunized by their first birthday, and 79% by the time they came for the examination. An additional 121 were then done, so that 90.5% had been protected.

Booster D-P-T.—In contrast to the small percentage of 1951 entrants who had been revaccinated, the physicians had given booster doses of DPT to 47% of these same children. Two thirds of these injections were given at the time of examination.

Of the 1952 group, 54% had been given booster doses. Less than half were done as late as the preschool examination (Figure 2).

Comments

The medical histories of the 668 children entering in 1951 showed that 107 previously had whooping cough. This may have been due to lack of immunization, or to delayed immunization. Reporting of this disease is very poor. For the county as a whole, only 63 cases were reported for the period 1946 through 1951. On the other hand, the more accurate mortality records show only 1 death attributed to pertussis in this period, in 1946.

None of the 1951 entrants gave a history of having had diphtheria, tetanus or smallpox. Reporting of these diseases is fairly accurate. During the period 1946 through 1951, there were county reports of 5 cases of diphtheria (4 in 1946, 1 in 1950), 1 case of tetanus in 1946, and no cases of smallpox. There was one death from diphtheria in 1946. This low number of cases might indicate that a high proportion of the population, especially children, had either artificially induced or naturally acquired immunity. Or the rate of exposure may have been low, in that few cases or carriers might have been present.

The health department visits the schools each Fall to give initial protection and booster doses to children between six and ten years of age.

Since evidence of previous vaccination is required for school attendance, only the very few cases overlooked by the teachers need to be vaccinated after entrance.

It seems evident that the requirement of evidence of vaccination on entrance to school, influences some parents to delay vaccination until the time of the preschool examination.

Approximately 10% of children enter school without previous DPT immunization. Practically all are given the first series shortly after, during the school visits.

In an effort to make parents more conscious of the need for early protection, the health department, in 1952, started sending a post card to every infant on its third month birthday. This card advises the baby to go to its family physician, or to the wellbaby clinic, for immunization and vaccination. It is signed by the Medical Society and the Health Department. This is a modification of the card advocating diphtheria toxoid, which has been sent by the Mayor and Commissioner of Health of Baltimore since 1933 (2).

Cowgill has reported a community survey in Wichita, of a 6% representative sample of all preschool children from 0 to 6 years of age, as of January 1, 1950 (3). He found that 31% of those under 1 year had been vaccinated. Comparison with older preschool children made him conclude that "for children born during the later years of the survey period, immunization for smallpox was performed less frequently and was delayed to a later age."

Our study shows a slight, but definite trend towards more frequent and earlier vaccinations. The records of children entering school in 1954 will probably show appreciably more than 31% vaccinated before their first birthday.

CONCLUSIONS

1. Information given by private physicians showed that only 25% of children entering first grade in 1951, had been vaccinated in the first year of life. Only 42% had been immunized with DPT by their first birthday.
2. Relatively few vaccinations and immunizations were performed after the first year, until the time of the preschool examination, when many were done.
3. Children entering school in 1952 showed a slight, but definite trend towards earlier and more frequent vaccination and immunization.

REFERENCES

(1) Hayman, C. R. Examinations by private physicians and dentists of first grade pupils in 1951. Md. Health Bull. **24:** 2, 1952

(2) Williams, Huntington. The city health officer looks at diphtheria prevention. Am. Jl. Pub. Health **25:** 425, 1935

(3) Cowgill, Donald O. The level of immunization of preschool children in Wichita. Am. Jl. Pub. Health **42:** 32, 1952

TRAUMATIC UNCONSCIOUSNESS

A Guide in Head Injury

RAYMOND K. THOMPSON, M.D.

Baltimore

Evaluation of the unconscious patient due to trauma is most frequently the responsibility of the general practitioner. This evaluation determines the proper care of the patient, and proper evaluation hinges on the question as to whether the patient, can be best cared for in his own doctor's hands or whether neurosurgical aid is needed.

Unconsciousness is one of the most reliable guides in the evaluation of a traumatic patient, if one realizes that, unconsciousness is not a single clinical state, but rather a series of stages like the rungs on a ladder. At the top of the ladder there is full consciousness and at the bottom is the stage of permanent unconsciousness, death. The transition between full consciousness and death, is variously divided. The following classification of unconsciousness which is admittedly not complete or applicable in all cases has been of great value in assessing the course which a head injury patient is taking and determining the therapy indicated.

Consciousness

Automatism
Confusion
Delirium } Unconsciousness
Stupor
Coma

Death

Consciousness represents that state in which an individual responds to stimuli and is able to recall the majority of his reactions. When this property of recall is truly absent, the patient according to this classification is unconscious. If an individual is able to recall actions which have taken place several minutes before, if he can repeat several digits which have been told to him several minutes before, then and only then is he fully conscious and responsible. If this recall is absent then the patient is neither conscious nor more important, responsible for his actions. This brings us to the lightest stage of unconsciousness, that of traumatic automatism.

Traumatic automatism is that light stage of unconsciousness in which the individual reacts appropriately to his environment but has lost the ability to recall. He is only aware of the stimuli as they are taking place; responds properly but does not record the pattern of reaction in memory. This patient will talk, walk, respond appropriately to stimuli but as soon as the action is over it vanishes from his mind as light from a lamp when it is extinguished. There is no recall and never will there be any recall of the incidents. These patients most frequently manifest this lack of memory by repeatedly asking the same question. All too frequently one hears the traumatized patient asking over and over again, "What happened to me?" or "What time is it?" Relatives are many times seen repeatedly answering the patient's questions, only to be asked the same question again in the course of several seconds when the answer is given again. There is no trace of recall by this patient. This man is unconscious. Any patient exhibiting such behavior should be cautiously observed over and over again to determine when full consciousness has returned or if unconsciousness is deepening. These individuals are obviously not responsible. They behave like automatons and almost reflexly will get in their cars and drive home if allowed to do so, only to wake the following morning, if all goes well, with no recollection of having had a head injury or having been seen by the physician. If all does not go well this is the type of patient who automatically goes home and goes to bed only to become more deeply unconscious during the night and is critically unconscious or dead in the morning. Traumatic automatism needs close observation until it disappears. If it disappears into full consciousness the doctor's close observation can be trusted to a member of the family and the arousing at intervals to full consciousness then becomes the treatment. If the patient, however, again slips into unconsciousness the observation should again come under the direct care of the physician or nurse trained in observation of the unconscious patient.

A downward trend in unconsciousness is marked by the next step down the ladder of unconsciousness that of *traumatic confusion.* This stage is readily known to all. It is typified by the classical intoxication seen in a state of acute alcoholism. The speech is slurred, the gait is drunken, movements are clumsy, and memory is obviously impaired. Response to stimuli is no longer accurate as in automatism but rather confused. A trend from automatism to confusion is a definite decline of consciousness and should further alert the physician for the patient has changed for the worse. A great many head injuries present to the doctor in this stage of unconsciousness. A trend upward in the conscious level to automatism and then to full consciousness indicates to the physician that improvement is progressing satisfactorily and that at that moment the patient needs no further therapy.

A similar though deeper stage of unconsciousness is the next step downward, that of agitated confusion or *traumatic delirium*. This stage is frequently evanescent and even may be missed going up or down the ladder of unconsciousness. When the confused traumatic suddenly becomes violently agitated, the level of consciousness is slipping. This further alerts us and such patients need constant observation. Again traumatic head injuries frequently present in this stage. Traumatic delirium is identical in patient behavior to that of acute manic delirium as seen in meningitis, alcoholism or hyperpyrexia. Response to vocal stimuli except possibly the most strong is lost.

Traumatic stupor is the next step downward in the ladder of unconsciousness. In this stage the patient lies quietly without moving except in response to stimuli. He responds to the pressure of his body on the bed and when a position becomes painful he will shift his position but appears generally to have "passed out" or is asleep. This is the stage of consciousness recognized by the layman as an unconscious patient. Sensations from a full bladder will arouse such a patient to delirium and on evacuation of the bladder he will again quiet down or slip into stupor. At all times the patient will respond to painful stimuli and to tickling stimuli.

Traumatic coma develops as the patient no longer responds to painful or tactile stimuli. In this stage of unconsciousness the patient makes no voluntary movement. The vital mechanisms of the circulatory and respiratory systems work involuntarily. Scratching the sole of the foot may elicit a reflex movement of the toes. The knee reflex may respond on tapping the patellar tendon but pinching the skin or supraorbital pressure fail to elicit a motor response on the part of the patient. One by one these fundamental reflexes will disappear as the patient goes deeper into coma and finally the corneal reflex, elicited by touching the cornea over the pupil, will disappear and at that point the patient passes into an irreversible stage of unconsciousness and shortly succumbs. A word must be said about the corneal reflex however and that is that any medication of the sedative group or the slightest amount of alcohol in the system will cause the corneal reflex to disappear. This is therefore a prognostic sign only in the absence of any medication or alcohol.

These five stages of unconsciousness; automatism, confusion, delirium, stupor, and coma are characteristic stages of unconsciousness regardless of the etiology of unconsciousness. We see these in the patient undergoing anaesthesia, with the patient passing rapidly to anaesthetic coma and following surgery gradually passing through these stages back to full consciousness. In stages of intoxication from alcohol or drugs the same transitions occur. How then can we use these clinical states as a guide in the evaluation of the traumatic?

In a head injury we deal with two factors; one the insults inflicted at the time of the injury; and two the insults to the brain which develop from disordered physiology.

Immediate

Concussion or jarring of the brain without structural change
Contusion or bruising of the brain
Laceration of the brain
Petechial hemorrhages in the brain
Alterations of the continuity of the bone around the brain

Delayed

Edema or swelling
Bleeding within the meningeal layers
Bleeding within the brain
Disordered cerebral circulation

The immediate insults of the injury are reflected in the patient by one of the above stages of consciousness. For example, the patient with a pure concussion, rapidly rallies from the immobile state of coma and begins to respond to stimuli and within minutes usually passes through the delirium, confusion stage where he shakes his head trying to clear his thoughts and after a short period of being dazed (usually automatism) he begins to recall and is fully conscious. In contradistinction, the patient with petechial hemorrhages scattered throughout the brain is in deep coma failing to respond to any stimulus. The corneal reflexes are absent. At most the four extremities will stiffen out into a reflex movement of decerebrate rigidity and death will be supervening before long. In between these are many variants but generally the patient who is gradually coming up in consciousness from coma to stupor to delirium to confusion to automatism is doing satisfactorily while the patient who is holding the same state of consciousness or is getting deeper into unconsciousness offers a more grave prognosis and indicates the need of help.

If following the initial injury the state of unconsciousness continues to lighten slowly or rapidly the patient's cerebral physiology is compensating for the insults. If however after the initial unconsciousness of the injury has been overcome, the patient begins to slip into automatism into confusion into delirium, into stupor or into coma then the battle is being lost, the disordered cerebral physiology is becoming decompensated and the outlook is bad unless the physiologic processes can be helped. In other words a clot removed, edema relieved, or cerebral circulation improved.

In summary then evaluation of the traumatic unconscious patient by determining whether he is progressing toward full consciousness or toward death is one of the most accurate means that the general practitioner has in knowing whether a head injury is progressing satisfactorily under his care or whether neurosurgical assistance in the management of the patient is necessary.

* * * * * *

AMERICAN MEDICAL EDUCATION FOUNDATION CONTRIBUTION FROM THE WOMAN'S AUXILIARIES

December 30, 1952

Mrs. Charles H. Williams, *President*
Woman's Auxiliary Medical and Chirurgical
Faculty of the State of Maryland
1632 Reisterstown Road
Baltimore 8, Maryland

Dear Mrs. Williams:

It goes without saying that the State Committee of which I am chairman, along with the American Medical Education Foundation, and of course our Society are deeply indebted to the Woman's Auxiliaries for a job more than well done with results as tangible as your generous gift which I have already forwarded.

I understand much credit is due Mrs. Albert E. Goldstein and her group within the Woman's Auxiliary of Baltimore City Medical Society for this particular sum, said contribution giving rise to complimentary remarks in re the abilities and talents of our ladies' groups which we have allowed (alas) to lie dormant lo this number of years.

Please be sure of our grateful appreciation for these and any future efforts in behalf of the American Medical Education Foundation.

Sincerely,
Newland E. Day, M.D., *Chairman*
State Committee to Cooperate
Medical Education Foundation

CC—Dr. George Yeager, *Editor*
State Journal—Medical
and Chirurgical Faculty

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

Dr. William S. Love, Professor of Cardiology at the University of Maryland, was the guest speaker at the January meeting of the Allegany-Garrett County Medical Society, held in the nurse's auditorium at the Memorial Hospital.

Dr. Love's paper was titled "Some of the newer diagnostic aids in the recognition of Cardiac Disease."

Dr. W. Royce Hodges, 122 Centre Street, Cumberland, was elected President of the Allegany-Garrett County Medical Society for this year. Dr. W. O. McLane of Frostburg was named Vice-President; Dr. R. Rhett Rathbone, 122 Centre Street, Cumberland, Secretary, and Dr. Leland B. Ransom, 41 Greene Street, Cumberland, Treasurer.

ANNE ARUNDEL COUNTY MEDICAL SOCIETY

GEORGE C. BASIL, M.D.

Journal Representative

At the January meeting of the Anne Arundel County Medical Society, the following officers were elected for 1953: Dr. J. Oliver Purvis, Annapolis, *President*; Dr. William J. French, Annapolis, *Vice-President*; Dr. J. Howard Beard, Annapolis, *Secretary-Treasurer*; Dr. Donald H. Hooker, Annapolis, *Board of Censors* (3 years); Dr. Frank M. Shipley, Annapolis, *Board of Censors* (2 years); Dr. Irving Ochs, Annapolis, *Board of Censors* (1 year); Dr. Bowie Grant, Shadyside, *Delegate*; Dr. William N. Thomas, Jr., Annapolis, *Alternate*.

BALTIMORE CITY

BALTIMORE CITY MEDICAL SOCIETY OFFICERS AND COMMITTEES

CONRAD ACTON, M.D., *Journal Representative*

The following officers were elected at the Annual Meeting of the Baltimore City Medical Society Friday, December 19, 1952, to serve for the year 1953: *President*, Wetherbee Fort; *Vice-President*, Lewis P. Gundry; *Secretary*, Edward F. Cotter; *Treasurer*, Robert C. Kimberly; *Board of Censors*, Samuel McLanahan (1953–1955); *Honor Committee*, Albert E. Goldstein (1953–1955); *Delegates* (1953), Bernard J. Cohen, Palmer H. Futcher; *Alternates*, James N. McCosh, John Newell Classen; *Delegates* (1953–1954), Conrad Acton, John S. Fenby, Wilson Grubb, John M. Haws, Harry F. Klinefelter, Jr., Zachariah R. Morgan, Edmund R. Novak, Thomas R. O'Rourk, Frank J. Otenasek, Ross Z. Pierpont, John E. Savage, Richard T. Shackelford, W. Kennedy Waller, Theodore E. Woodward; *Alternates*, M. Paul Byerly, Charles R. Goldsborough, Raymond E. Lenhard, Edwin B. Jarrett, D. C. MacLaughlin, James W. Nelson, John M. Scott, Mary L. Hayleck, Otto C. Brantigan, Carleton C. Douglass, George W. Murgatroyd, Jr., Edward F. Lewison, J. Brooke Boyle Jr., Howard M. Bubert.

Dr. Wetherbee Fort, the President, has appointed the following Committees for 1953:

ADVISORY COUNCIL TO THE WOMAN'S AUXILIARY:

J. Arthur York, *Chairman*, Newland E. Day, Edward Johnson, Frank Supplee.

CONSTITUTION AND BY-LAWS COMMITTEE:

Moses Paulson, *Chairman*, Marius P. Johnson, Lawrence R. Wharton.

COMMITTEE ON EMERGENCY MEDICAL CALLS:

Paul E. Carliner, *Chairman*, Thomas W. Harris, Clewell Howell, Louis F. Klimes, George Murgatroyd, J. Charles Norton, Jr., Samuel Revell, John M. Scott, Howard Warner, Marion E. Wilson.

ADVISORY COUNCIL TO THE EXECUTIVE COMMITTEE:

J. Edmund Bradley, Edwin B. Jarrett, Lauriston L. Keown, Raymond E. Lenhard, Samuel Whitehouse, J. Donald Woodruff.

COMMITTEE ON GERIATRICS:

Herman Seidel, *Chairman*, Alfred Cole, Charles R. Goldsborough, Robert L. Jackson, Louis Krause, George G. Schlesinger, W. H. Woody.

LEGISLATIVE COMMITTEE:

Daniel J. Pessagno, *Chairman*, Raymond F. Helfrich, Marius P. Johnson, C. F. Karns, Albert J. Mace, Erwin E. Mayer, George McLean, William F. Pearce.

MAGISTRATE'S COMMITTEE:

Roy O. Scholz, *Chairman*, H. Clay Bowie, Howard M. Bubert, Walter Buck, William G. Helfrich, Nathan B. Herman.

JOINT COMMITTEE OF MATERNAL MORTALITY:

Huntington Williams, *Chairman*, D. McClelland Dixon, Louis H. Douglass, Nicholson J. Eastman, W. Drummond Eaton, W. Thurber Fales, Ex-officio, John M. Haws, Hugh B. McNally, John E. Savage, Isadore A. Siegel.

MEMBERSHIP COMMITTEE:

William E. Gilmore, *Chairman*, Philibert Artigiani, David Bacharach, Edmund G. Beacham, George H. Brouillet, Pierson M. Checket, Anthony F. DiPaula, Karl W. Ebeling, William L. Fearing, William L. Garlick, J. Robert Gibbons, John J. Gould, George Govatos, Hyman L. Granoff, Francis L. Grumbine, I. Bradshaw Higgins, Robert L. Jackson, Arthur Karfgin, Vernon C. Kelly, Irvin P. Klemkowski, J. H. Mason Knox, III, Fred T. Kyper, George D. Lippy, William D. Lynn, Erwin E. Mayer, Charlotte McCarthy, Walter C. Merkel, Mitchell H. Miller, Joseph E. Muse, Jr., Nathan E. Needle, Patrick C. Phelan, Jr., H. William Primakoff, Thomas E. Roach, Thomas Edgie Russell, John F. Schaefer, George Sharfatz, Martin L. Singewald, William G. Speed, III, William J. Supik.

COMMITTEE TO FORMULATE A POLICY OF HANDLING PROFESSIONAL PROBLEMS:

William H. Smith, *Chairman*, C. Holmes Boyd, Charles N. Davidson, Max R. English, J. Howard Franz, Frank J. Geraghty, Edward S. Stafford.

PROGRAM COMMITTEE:

J. Arthur Weinberg, *Chairman*, Otto C. Brantigan, R Adams Cowley, Raymond M. Cunningham, Samuel Morrison, S. Edwin Muller, James C. Owings, Francis F. Schwentker, William H. Smith.

PUBLICITY COMMITTEE:

Palmer H. Futcher, *Chairman*, Ernest Cornbrooks, Jr., Ernest S. Cross, Jr., Jacob Charles Handelsman, John A. Nesbitt, Jr., Harry M. Robinson, Jr.

COMMITTEE ON PUBLIC MEDICAL EDUCATION:

Amos R. Koontz, *Chairman*, George O. Eaton, J. Wesley Edel, Houston S. Everett, H. Hanford Hopkins.

ANNUAL REPORT FOR THE YEAR 1952 OF THE CHAIRMAN OF THE ANESTHESIOLOGY SECTION

OTTO C. PHILLIPS, M.D.*

I. During the past year, so as to stimulate more active participation on the part of the members in the activities of the Section, a number of committees were set up, including in all fourteen of the total membership of sixteen, excluding the Chairman. Most of these committees have since been set up in the Constitution as standing committees.

II. *Meetings*. There were eight meetings held during the year, at six of which visiting speakers from out of town were invited.

1. January 9, 1952. Brig. General Sam Seeley, Chief of the Surgical Section, The Walter Reed Army Hospital, discussed, "The Pathogenesis of the Shock States."
2. Feb. 4, 1952. Dr. Donald Stubbs of Washington, D. C. spoke on "Acute Clinical Emergencies."
3. March 3, 1952. Dr. George Thomas of Pittsburgh, Pa., discussed with demonstrations "Operating Room Explosions."
4. April 1, 1952. Business meeting and presentation and discussion of anesthesia case studies.
5. May 5, 1952. Edward Tuohy of Los Angeles, California discussed "Current Trends in the Practice of Anesthesiology."
6. October 6, 1952. Dr. William Derrick, Director of the Department of Anesthesiology of the Peter Bent Brigham Hospital, Boston, discussed "Anesthesia in Mitral Valvuloplasties."
7. November 25, 1952. Dr. Robert Smith, Director of the Department of Anesthesiology of The Children's Hospital, Boston, discussed "Pre and Post-anesthetic Care of the Pediatric Patient."
8. December 16, 1952. Dinner at the Hopkins Club, and election of officers as follows:

Chairman	Dr. Edward Lederman
Chairman-elect	Dr. Charles Hobelmann
Secretary-Treasurer	Dr. Leah Camp

III. *Membership*. During 1952 three members were added and three lost. Added were Drs. Lionel Glassman, Weadon Johnson, and Donald Proctor. Lost were Drs. Julian Holly (deceased), Fred Bampfield (deceased), and Weadon Johnson (now practicing in another state).

IV. *Constitution and By-Laws*. To answer the changing needs of the Section, the Constitution was thoroughly revised and accepted at the annual meeting in December.

V. *Anesthesia Study Committee*. On November 21,

---

* Chairman, Anesthesiology Section, 1952.

1952, a resolution was passed by the Baltimore City Medical Society requesting the Baltimore City Health Department undertake a study of mortality and morbidity associated with anesthetic mishaps, and urging the members to cooperate in the undertaking.

VI. The Maryland State Industrial Commission during the year set up a new scale of anesthetic fees for the compensation cases, based on the time involved rather than the simple "major-minor" differentiation as previously.

BALTIMORE COUNTY MEDICAL ASSOCIATION

Letter to Dr. Charles H. Williams

Dear Dr. Williams,

I am sorry to be so extremely late in writing to thank you for your kindness to me when I visited your country earlier this year. I should not like the Christmas season to pass completely without sending you a word of thanks.

My visit to America ended as far back as the beginning of June but the memory still remains green and pleasant. I saw and heard an immense amount which was of great interest and value to me. Indeed, so much was new that it is only now I am getting things properly into perspective. There are several interesting developments here in general practice. Earnings of practitioners have been considerably raised as a result of arbitration between them and the Government. Within the past week a College of General Practice has been founded. This will correspond fairly closely in constitution and aims to the American Academy of General Practice. It is, of course, too soon yet to say how successful it will be but, from what I hear, it is likely to be well supported by practitioners. General practice in this country has been growing less in status for some time, but I think it would be reasonable now to claim that there is a definite resurgence. One of the greatest needs here, as I no doubt told you, is for general practitioners to get associated with hospital work. At the present moment that has been reduced almost to the point of vanishing entirely. There is at the moment quite a definite effort being made to rectify that unfortunate state of affairs, and I think that the new College will be able to help just as the American Academy has done in this problem.

I heard a great deal about American general practice in various places but the practical side was, of course, most valuable to me. That is why I am so grateful to you for allowing me to see some of your own practice. When I am asked by doctors here about what I saw in the United States it is, quite naturally, my days spent in seeing the actual running of practices that are of greatest interest. Please therefore accept my very grateful thanks for your help and also for your very great personal kindness and hospitality to me.

With kindest regards,
Yours sincerely,

(Signed) Charles M. Fleming

2 Peel Terrace,
Edinburgh, 9, Scotland.
24th December, 1952.

* * * * *

AN INVITATION

Dr. David P. Barr, Professor of Medicine, Cornell University, will speak on "Chemical Factors in the Pathogenesis of Arteriosclerosis" on Monday 23rd of March in Gordon Wilson Hall of the University Hospital. This lecture is given under the auspices of the Alpha Omega Alpha fraternity of the University of Maryland. The members of Medical and Chirurgical Faculty are invited.

Library

A FEW OF THE RECENT PUBLICATIONS BY FACULTY MEMBERS

Abeshouse, B. S., The differential diagnosis of pancreatic cysts from renal cysts, Sinai Hosp. J. **1:** 26–46, November 1952

Abeshouse, B. S., Why publish a hospital staff journal? Sinai Hosp. J. **1:** 3–7, November 1952

Austrian, R., and others, A comparison of the efficacy of chloramphenicol (chloromycetin) and of penicillin in the treatment of pneumococcal lobar pneumonia, Bull. Johns Hopkins Hosp. **91:** 323–329, November 1952

Baptisti, Arthur, Jr., Brief, painless parturition, Am. J. Obst. & Gynec. **64:** 923–925, October 1952

Berman, E. F., The plastic esophagus, J. Internat. Coll. Surgeons **18:** 695–699, November 1952

Blalock, Alfred, William Stewart Halsted, an appreciation on the centenary of his birth, J. A. M. A. **150:** 1082–1084, November 15, 1952

Bracher, A. N., and Koontz, A. R., Mediastinal bronchogenic cyst and Klippelfeil syndrome, J. A. M. A. **150:** 1006–1009, November 8, 1952

Brackin, J. T., Jr., Miller, J. M., and Bell, W. H., Roentgen appearance of the small intestine in tuberculous peritonitis before and after streptomycin therapy, Am. J. Roentgenol. **68:** 887–893, December 1952

Bradley, J. E., The control of vomiting, Modern Medicine **20:** 71–74, October 15, 1952

Chandler, C. A., and Goltz, E. von der, Studies on the effect of aureomycin on the production of penicillinase by staphylococci, Bull. Johns Hopkins Hosp. **91:** 475–479, December 1952

Chesney, A. M., A plan for the instruction of medical students in preventive medicine and public health, J. Med. Educ. **27:** 387–392, November 1952

Conn, J. H., The treatment of anxiety states in children by play interviews, Sinai Hosp. J. **1:** 57–65, November 1952

Crigler, J. F., Jr., Silverman, S. H., and Wilkins, Lawson, Further studies on the treatment of congenital adrenal hyperplasia with cortisone. IV. Effect of cortisone and compound B in infants with disturbed electrolyte metabolism, Pediatrics **10:** 397–413, October 1952

Deane, G. E., and Hidey, R. M., Jr., The successful treatment of C. diphtheriae acute bacterial endocarditis with chloramphenicol, penicillin, and streptomycin, J. Pediat. **41:** 473–478, October 1952

DeCarlo, John, Jr., Tramer, Arnold, and Startzman, H. H., Jr., Iodized oil aspiration in the newborn, Am. J. Dis. Child. **84:** 442–445, October 1952

Douglass, L. H., Repair of obstetric soft tissue damage immediately post partum, J. A. M. A. **150:** 1061–1063, November 15, 1952

Ellis, F. A., and Bundick, W. R., Appraisal of tropical use of antihistamines, J. A. M. A. **150:** 773–776, October 25, 1952

Feldman, Maurice, How often do secondary peptic ulcers occur at a new site (editoral), Revista Brasileira de Gastroenterologia **4:** 863–864, Setembro-Outubro, 1952

Feldman, Maurice, and Myers, Philip, The coexistence of carcinoma of the stomach and esophageal hiatus gastric hernia, Am. J. M. Sc. **224:** 519–521, November 1952

Follis, R. H., Jr., Burnett, J. M., and Laschever, Z. E., The effect of specific antibody on the oxygen consumption and growth of S. Marcescens, S. Typhosa and SH. Paradysenteriae, Bull. Johns Hopkins Hosp. **91:** 463–474, December 1952

Follis, R. H., Jr., and Park, E. A., Some observations on bone growth, with particular respect to zones and transverse lines of increased density in the metaphysis, Am. J. Roentgenol. **68:** 709–724, November 1952

Follis, R. H., Jr., Park, E. A., and Jackson, Deborah, The prevalence of rickets at autopsy during the first two years of age, Bull. Johns Hopkins Hosp. **91:** 480–497, De cember 1952

Friedenwald, J. S., Diabetic retinopathy, J. A. M. A. **150:** 969–971, November 8, 1952

Glick, S. S., The Jew in medicine, Sinai Hosp. J. **1:** 66–79, November 1952

Goodwin, W. E., and Scott, W. W., Phalloplasty, J. Urol. **68:** 903–908, December 1952

Grafflin, A. L., and Bagley, E. H., Studies of peripheral blood vascular beds, Bull. Johns Hopkins Hosp. **92:** 47–73, January 1953

Guild, H. G., Grubb, Wilson, Chu, M. Y. F., and Sidbury, J. B., Jr., Vascular complications of juvenile diabetes, J. Pediat. **41:** 722–739, December 1952

Guttmacher, A. F., Response at the dinner given him at the Woodholme Country Club, May 28, 1952, Sinai Hosp. J. **1:** 8–12, November 1952

Hardy, J. B., Proctor, D. F., and Turner, J. A., Bronchial obstruction and bronchiectasis complicating primary tuberculous infection, J. Pediat. **41:** 740–755, December 1952

Harrison, H. E., and Harrison, H. C., Further studies of the effects of citrate feeding on the calcium, phosphorus, and citrate metabolism of rachitic infants, J. Pediat. **41:** 756–765, December 1952

Hendrick, J. W., and Ward, G. E., Treatment of intraoral cancer, J. A. M. A. **150:** 1099–1103, November 15, 1952

Hilbish, T. F., and Morgan, R. H., Radiology—Cardiac mensuration by roentgenologic methods, Am. J. M. Sc. **224:** 586–596, November, 1952

Hill, L. B., Infantile personalities, Am. J. Psychiat. **109:** 429–432, December 1952

Hingson, R. A., and Figge, F. H. J., Survey of the development of jet injection in parenteral therapy, Current Res. in Anesth. & Analg. **31:** 361–366, November–December 1952

Hopkins, H. H., Dermatitis herpetiformis, treatment with sulfonamides, Bull. Johns Hopkins Hosp. **92:** 1–6, January 1953

Hull, H. C., and Ganey, J. B., The Henry approach to femoral hernia, Ann. Surg. **137:** 57–60, January 1953

Jennings, E. R., Mansberger, A. R., Jr., Smith, E. P., and Yeager, G. H., A new technique in primary tendon repair, Surg., Gynec. & Obst. **95:** 597–600, November 1952

Jones, H. W., Jr., Wade, Ruth, and Goldberg, Benjamin, Biochemical and histochemical alkaline glycerophosphatase in normal endometrium, endometrial hyperplasia, and adenocarcinoma, Am. J. Obst. & Gynec. **64:** 1364–1367, December 1952

Jones, H. W., Jr., Wade, Ruth, and Goldberg, Benjamin, Phosphate liberation by endometrium in the presence of adenosinetriphosphate, Am. J. Obst. & Gynec. **64:** 1118–1124, November 1952

Koelle, G. B., Wolfand, Lillian, Friedenwald, J. S., and Allen, R. A., Localization of specific cholinesterase in ocular tissues of the cat, Am. J. Ophth. **35:** 1580–1584, November 1952

Koontz, A. R., Tantalum gauze in hernia repair, Sinai Hosp. J. **1:** 13–20, November 1952

Koontz, A. R., and Coxe, W. S., Effect of implanted tantalum mesh on the growth of young individuals, Ann. Surg. **137:** 77–79, January 1953

Krantz, J. C., Jr., Live and help live, Current Medical Digest **19:** 29–32, December 12, 1952

Langworthy, O. R., Emotional issues related to certain cases of blepharospasm and facial tics, A. M. A., Arch. Neurol. & Psychiat. **68:** 620–628, October 1952

Lovitt, W. V., Jr., and Corzine, W. J., Jr., Dissecting intramural hemorrhage of anterior descending branch of left coronary artery, A. M. A., Arch. Path. **54:** 458–462, November 1952

Macht, A. H., and Beissinger, Heinz, Unilateral agenesis of right lung, Sinai Hosp. J. **1:** 47–51, November 1952

Macht, D. I., Pharmacology of succino-nitrile, Arch. Internat. Pharmacody. **91:** 16–24, September 1952

Macht, S. H., and Kutz, E. R., Detection of faulty roentgenoscopic technique by direct radiation measurements, Am. J. Roentgenol. **68:** 809–814, November 1952

Mandy, A. J., Mandy, T. E., Farkas, Robert, and Scher, Ernest, Is natural childbirth natural? Psychosom. Med. **14:** 431–438, November–December 1952

Moore, J. E., and Mohr, C. F., The incidence and etiologic background of chronic biologic false-positive reactions in serologic tests for syphilis: preliminary report, Ann. Int. Med. **37:** 1156–1161, December 1952

Murdock, H. M., and Eaton, M. T., Jr., Music as an adjunct to electroshock therapy, J. Nerv. & Ment. Dis. **116:** 336–339, October 1952

Notkin, Herbert, Rogerson, Bettie, Davis, Wilfrid, and Taback, Matthew, Drug experience in two programs for medical care, Pub. Health Rep. **67:** 797–801, August 1952

Otenasek, F. J., and Markham, James, Transient loss of vision following cerebral arteriography, J. Neurosurg. **9:** 547–551, September 1952

Pearson, P. H., Peck, J. L., and Livingston, Samuel, Fatal pancytopenia following therapy with nuvarone (3-methyl, 5-phenylhydantoin). A case report, Bull. Johns Hopkins Hosp. **91:** 341–344, November 1952

Reid, J. R., and Finesinger, J. E., The role of definitions in psychiatry, Am. J. Psychiat. **109:** 413–420, December 1952

Ruben, M. E., and Abeshouse, B. S., A rare complication of aortography and renal arteriography by percutaneous retrograde catheterization of the femoral artery, Sinai Hosp. J. **1:** 52–56, November 1952

Sacks, M. S., Workman, J. B., and Jahn, E. F., Diagnosis and treatment of acquired hemolytic anemia, J. A. M. A. **150:** 1556–1559, December 20, 1952

Scarborough, W. R., Davis, F. W., Jr., Baker, B. M., Jr., Mason, R. E., and Singewald, M. L., A review of ballistocardiography, Am. Heart J. **44:** 910–946, December 1952

Scarborough, W. R., Mason, R. E., Davis, F. W., Jr., Singewald, M. L., Baker, B. M., Jr., and Lore, S. A., A ballistocardiographic and electrocardiographic study of 328 patients with coronary artery disease; comparison with results from a similar study of apparently normal persons, Am. Heart J. **44:** 645–670, November 1952

Schwentker, F. F., Dr. Park as a teacher, J. Pediat. **41:** 637–640, December 1952

Shulman, L. E., Schoenrich, E. H., and Harven, A. M., The effects of adrenocorticotropic hormone (ACTH) and cortisone on sarcoidosis, Bull. Johns Hopkins Hosp. **91:** 371–415, November 1952

Silverman, S. H., Migeon, Claude, Rosemberg, Eugenia, and Wilkins, Lawson, Precocious growth of sexual hair without other secondary sexual development; "Premature pubarche," a constitutional variation of adolescence, Pediatrics **10:** 426–432, October 1952

Taussig, H. B., Congenital malformations of the heart, J. Pediat. **41:** 853–859, December 1952

Taussig, H. B., Diagnosis and management of common malformations of the heart, Circulation **6:** 930–940, December 1952

Walsh, F. B., and Smith, G. W., The ocular complications of carotid angiography, J. Neurosurg. **9:** 517–535, September 1952

Weinberg, Tobias, A study of the effects of efocaine upon nerves, muscle, skin and subcutaneous tissue, Sinai Hosp. J. **1:** 21–25, November 1952

Wells, T. L., and Robinson, R. C. V., Annular constrictions of the digits, A. M. A., Arch. Derm. & Syphil. **66:** 569–572, November 1952

Wilkins, Lawson, The diagnosis of the adrenogenital syndrome and its treatment with cortisone, J. Pediat. **41:** 860–874, December 1952

Winiarz, W. V., and Hoffman, Reuben, Electroshock therapy in psychotic patients with pulmonary tuberculosis, J. Nerv. & Ment. Dis. **116:** 330–335, October 1952

Zeligman, Israel, Graying of hair following epilating doses of x-rays, A. M. A., Arch. Derm. & Syphil. **66:** 627–629, November 1952

Zierler, K. L., Levy, R. I., and Andres, R., Dissimilation of glucose-1-phosphate and of fructose-1,6-phosphate by isolated rat diaphragm and by cell-free effluent from rat diaphragm, Bull. Johns Hopkins Hosp. **92:** 7–25, January 1953

Zierler, K. L., Folk, B. P., Lilienthal, J. L., Jr., On the mechanism of action of α-tocopheryl phosphate, with special reference to carbohydrate metabolism of striated muscle. I. Modification of epinephrine effect (hyperlactacidemia) by α-tocopheryl phosphate in the rat, Bull. Johns Hopkins Hosp. **92:** 26–31, January 1953

Zierler, K. L., Andres, R., Levy, R. I., Anderson, H. M., and Lilienthal, J. L., Jr., On the mechanism of action of α-tocopheryl phosphate, with special reference to carbohydrate metabolism of striated muscle. II. Effect on the capacity of rat diaphragm to dissimilate hexose phosphates, Bull. Johns Hopkins Hosp. **92:** 32–40, January 1953

Zierler, K. L., Levy, R. I., and Lilienthal, J. L., Jr., On the mechanism of action of α-tocopheryl phosphate with special reference to carbohydrate metabolism of striated muscle. III. Inhibition of insulin-induced glycogenesis in isolated rat diaphragm, Bull. Johns Hopkins Hosp. **92:** 41–46, January 1953

AUTOMOBILE CLUB OF MARYLAND

RICHARD A. HARTMAN*

The Automobile Club of Maryland practices preventative medicine.

Believing that an enlightened public is one of our best weapons against traffic accidents, the Automobile Club of Maryland in cooperation with the educators of the State has long fostered safety education in our schools from kindergarten to college.

Monthly traffic safety guides for teachers are one of the aids furnished by the Club. Written by experienced educators around a different safety rule each month, the Guides are available on four levels, primary, upper primary, junior high school and rural. Dr. Harry Bard, Assistant Director of Curriculum, Baltimore City Board of Education, was commissioned to write the guides for junior high schools this year. The Automobile Club distributes a total of 4,300 Guides to Maryland schools each month. In addition, 3,100 posters and 31,000 crayon cards for the primary grades are distributed monthly.

* Director of Traffic, Engineering and Safety, Baltimore 1, Maryland.

Health Departments

STATE DEPARTMENT OF HEALTH

The Hospital Inpatient Program

HERBERT NOTKIN, M.D.*

There has been widespread discussion in the past two decades concerning the role of the State in the provision of medical care. This discussion will concern the part which the Maryland State Government has played in a program providing a specific type of medical care (hospitalization) for one hundred and forty-two years.

State appropriations to voluntary hospitals have the primary purpose of helping low-income residents of Maryland finance hospital care.

History

Maryland has given financial aid to hospitals since 1811, but records prior to 1900 reveal no legal or other definitive criteria for these grants. It can only be assumed that hospitals in financial distress addressed individual appeals to the State. The absurdities which can result from such haphazard methods are illustrated by an appropriation of $500 (in 1900) "to be used in erecting and maintaining a hospital at Frederick."

Starting in 1902, appropriations to hospitals were handled by the newly appointed Board of State Aid and Charities. In 1939 the State Department of Public Welfare was created and took over the responsibilities of the Board of State Aid and Charities. The last major change in departmental responsibility occurred in 1949, when administration was transferred to the State Department of Health, except for determination of the financial eligibility of individual patients, which was retained by the Welfare Department.

The total appropriation to hospitals increased from $95,600 in 1902 to $273,450 in 1910. By this latter year, State officials were beginning to show concern both over the large expenditures and the method of making payments. The 1910 report of the Board of State Aid and Charities contained the following comment:

> "While the members of the Board are in complete sympathy with the work of the hospitals and think it is the duty of the State to look after and provide for the sick, we are strongly of the opinion that some system should be devised by which the State should know what it is getting for its money."

This concern grew to such proportions that in 1914 the same Board filed a majority report containing the recommendation that the State take over the voluntary hospitals. A simultaneous minority report recommended the continuation of the existing program. The General Assembly adopted the minority report, and no serious questions as to the soundness of this approach have since been raised.

In its efforts to establish a more satisfactory basis of remunerating hospitals, the Board of State Aid and Charities evolved the principle of paying for services rendered in lieu of lump sum appropriations. Beginning in 1912, this Board tried to arrive at a per diem rate. The first rate worked out was $1.67 per day. The schedule of costs used in computing the rate was strikingly similar to that used in Maryland today. Authority for making payments on the basis of earnings rather than appropriations was not obtained until 1918. However, even after legislative approval of this principle was secured, hospitals continued to receive their entire appropriation, whether or not it was actually earned.

A study of the program was made nearly 20 years later by a gubernatorial commission. Its report, released in 1938, contained the following recommendations:

1. The establishment of standards by which a patient qualified for care at State expense.
2. The requirement that hospitals furnish data for use by the State as a basis for determining eligibility.

In 1939, when the Department of Public Welfare replaced the Board of State Aid and Charities, it was authorized both to establish rates of payment and to determine eligibility of patients. In 1943, the Department began the individual determination of eligibility through the caseworkers in the local welfare departments. This system is still in effect.

---

* Assistant Chief, Bureau of Medical Services and Hospitals, Maryland State Department of Health.

When administration of the program was transferred to the State Department of Health in 1949, a number of administrative changes (described below) were inaugurated.

State payment per patient day rose gradually from $1.67 in 1918 to $5.00 by 1946. The General Assembly authorized per diem payments to be raised to a ceiling of $10.00 in 1947 and $12.00 in 1952. The financial growth of the program can be seen in Figure 1 (Annual appropriations).

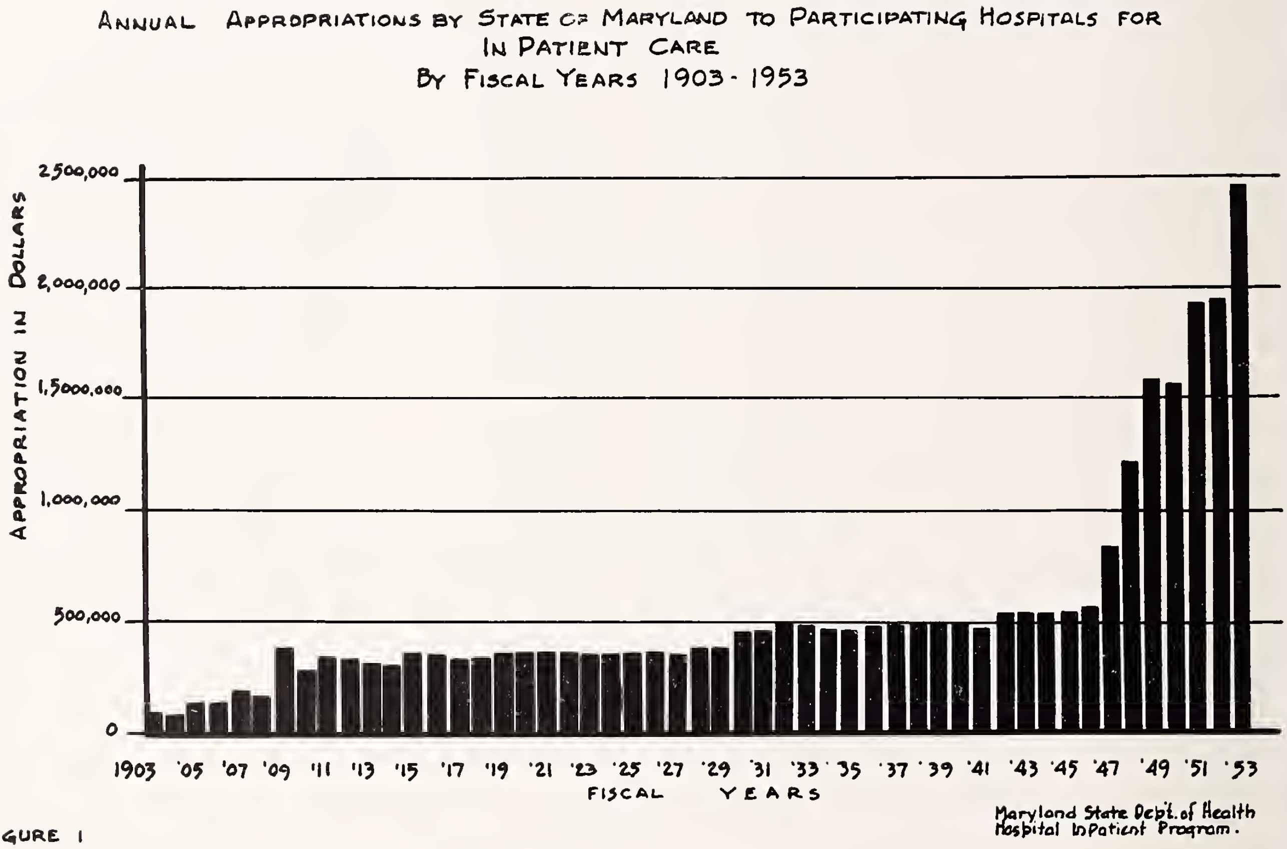


FIGURE I

Fig. 1

General Administration

Since July 1, 1949, the program has been administered by the Division of Hospital Services of the Bureau of Medical Services and Hospitals. This Bureau is responsible for a variety of medical care programs, of which the Hospital Inpatient Program is (from the point of view of cost) by far the largest. Policies are determined with the aid of an advisory body known as the Council on Medical Care, which is set up by law to advise the Health Department on its medical care programs. It is composed of members of the various professions involved, representatives of the medical schools, and *ex-officio* members, such as the Director of the State Department of Welfare and the Commissioner of Mental Hygiene. The Council refers hospital problems to its subcommittee on Hospital Services, consisting of representatives of the Council and the Maryland Hospital Association. Final decisions on Council recommendations rest with the State Board of Health. No policy decisions are made by State employees, although they are freely consulted by the advisory and policy-making bodies mentioned above. This system, although slightly cumbersome in practice, has made for outstandingly good relationships between the hospitals and the Health Department.

The Participating Hospitals

A total of 36 general hospitals scattered throughout the State participate in the program (one Eye, Ear and Throat Hospital is included with this group).

Included are all licensed, non-proprietary hospitals in the State with the following exceptions:

1. Hospitals owned by the Federal and State governments, and the City of Baltimore (hospitals owned by county governments are included).
2. A few voluntary hospitals which have not applied for participation.
3. Two orthopedic hospitals which receive financial aid from the Crippled Children's Program.

Eight special voluntary hospitals treating such conditions as chronic illness, tuberculosis, epilepsy and mental illness also participate.

The hospitals vary in size from community hospitals of less than 50 beds to a 1,000 bed university teaching hospital. Patients certified as eligible for care at State expense may apply for admission at the participating hospital of their choice, thus making it possible for residents of rural areas to seek care in large urban hospitals when necessary. Admission depends on the availability of appropriate beds and the decision of the medical staff of the hospital to which the patient applies.

SERVICES AND APPROPRIATIONS

In the fiscal year ending June 30, 1952, the program provided 219,213 days of care in general hospitals. Hospitals also rendered 7,790 days of care to eligible patients for which they were not paid due to budgetary inadequacy in this year. The exact number of patients treated cannot be estimated because of re-admissions, but there were 14,503 discharges under the program during this period. The average length of stay was 15.5 days, compared to 8.6 days for all inpatients in the same hospitals for the same time period.

For this same fiscal year the total State expenditures under the program for general hospitals were $1,674,923. In addition, the City of Baltimore spent $408,348 for its own residents hospitalized within the City. The financial effect of this program varies markedly from hospital to hospital. For the 1951–52 fiscal year earnings of individual hospitals ranged from $5,165 to $450,619. A possibly more useful way of expressing this is the ratio of State-aided days of care to total days of care rendered by each participating hospital. This varies from 0.9% to 40.1%.

The appropriation for a given fiscal year is not an arbitrary figure. It is based on the number of days of care rendered by each hospital to eligible patients during the last complete fiscal year. Each approved day of care rendered is counted, regardless of whether or not payment was actually made. The number of days is multiplied by either the per diem cost reported by the hospital on the Government Reimbursable Cost Statement, or the $12.00 ceiling, whichever is lower. Appropriations made by local governments for care of individual patients are subtrated from this sum before submission of the budget request to the Governor.

The eight special hospitals are budgeted in a similar manner to the general hospitals, except that the ceiling on their per diem payment is $3.00 per day for the fiscal year ending June 30, 1953. Negotiations to make this figure more realistic are now in progress.

FISCAL AND ADMINISTRATIVE PROCEDURES

In order to receive payment for inpatient services rendered to an individual patient, the hospital must present a certificate of his eligibility to the Department of Health. This certificate may be obtained either before or after admission. If the patient cannot visit the nearest welfare office, a welfare caseworker may visit him in the hospital. Eligibility is determined on the basis of one year's residence in the State and compliance with objective standards of income and financial resources in relation to family size. Recipients of public assistance (indigent) are automatically eligible for the program, but in 1951–52 they constituted only 22.5% of the patients hospitalized. The other 77.5% was made up of the medically indigent. Eligibility standards for the medically indigent are adjusted to variations in living costs in different counties. For example, the maximum income which will allow eligibility for a member of a four-person family varies from a high of $2,880 to a low of $2,700.

It should be noted that these income scales are much higher than those used to determine eligibility for the medically indigent under the County Medical Care Program. The corresponding scales for the latter program are $1,452 to $1,272. This difference obtains because hospitalization is generally much more expensive than home and office care, so that many people who can afford care for minor illnesses cannot pay for hospitalization. This explains why there are many people eligible for a State-aided bed in a hospital who are not eligible for the County Medical Care Program.

The monthly gross earnings for each hospital are calculated as the least of (1) ward charges for approved days care for patients discharged during the month, (2) per diem cost multiplied by the number of approved days care, or (3) the $12.00 ceiling multiplied by the number of approved days care. The gross earnings are then reduced by 50% of all collections from the patient, his family, partial insurance coverage or other sources to arrive at the hospital's net monthly earning.

At the end of the fiscal year, any funds not earned by hospitals which have rendered less than their expected quota of care for State-aided patients are distributed among those hospitals whose earnings have exceeded their appropriations. Any available supplemental funds are prorated on the basis of each hospital's overearnings.

Regulations include administrative controls on length of stay. A certificate is automatically valid for a maximum of 35 days from the admission date. If a patient stays more than 35 days, the hospital must request an extension of State-aid. This request is reviewed by a physician on the Health Department staff and may be granted or refused on either medical or social grounds. Extensions are always granted if a patient needs general hospital care for medical reasons. If this type of care is not needed, extensions may still be granted if there is evidence that the hospital is actively attempting to discharge the patient to his home or a less expensive appropriate facility, such as a nursing home. Extensions are refused if such facilities are available but the hospital keeps the patient for teaching, research or other reasons.

The Department works closely with hospital medical and social service staffs and with other community agencies in a continuous attempt to have patients occupy the most appropriate available facility. An experienced public health nurse on the department staff, as well as public health nurses and social workers in local health departments constantly try to relocate patients who no longer need general hospital care.

Other Medical Care Programs

No description of this program would be adequate without a brief listing of the other medical care programs and facilities in Maryland which render service to many patients who might otherwise occupy relatively scarce and expensive general hospital beds.

1. *Home Medical Care Program*—The State-wide system of medical care in the home, office and nursing home (including drugs), allows many low income residents to receive treatment on a non-hospitalized basis.
2. *Hospital Outpatient Program*—Hospitals are reimbursed for outpatient services to a large group of low income citizens. This service relieves the pressure on general hospital beds both by treating patients who might otherwise be hospitalized and by allowing for earlier discharge of patients who require only some of the specialized facilities of a general hospital.
3. *State and local Chronic Hospitals*—These hospitals serve many chronically ill people at lower costs than those which prevail in general hospitals. As chronic hospital beds become available, transfer of suitable patients from general hospitals is arranged.
4. *State Tuberculosis Hospitals*—Most tuberculosis patients are treated in State-owned hospitals which provide services equivalent to those in general hospitals (except major surgery).
5. *State Mental Hospitals*—These provide both general medical and psychiatric care to persons committed on a legal or voluntary basis.

These and other programs and facilities tend to decrease the utilization of general hospital beds with concomitant lessened public financial liability for hospitalization of low income citizens.

Accomplishments and Problems

Over the last 50 years the hospitals of Maryland and a number of State agencies have achieved the following results in the provision of State-aid for needy citizens in hospitals:

Acceptance of the principle of support to voluntary hospitals by making payments on behalf of low income patients.

Payment on the basis of services actually rendered to eligible patients instead of lump sum grants.

Payment on a less than cost basis in most cases so that the hospital retains its role as a charitable institution.

Determination of eligibility by a State agency rather than by the individual hospital, thus assuring consistency.

Preparation of budgets on the basis of service rendered rather than by expediency or on some arbitrary basis.

Administrative control over length of stay.

Provision of other facilities and programs to relieve general hospitals of many patients no longer needing their services and aiding in placement of such patients in more appropriate facilities.

Consultation on all policy changes with hospital representatives.

Vesting of official administrative responsibility in the Health Department.

While much progress has been made over the years, the following serious problems must still be faced:

What is the relative responsibility of the State, the local Government and the hospital in providing hospital care to needy patients?

Is the relative responsibility the same for persons on public assistance as for those classified as medically indigent?

What principles should be followed in determining eligibility of medically indigent people for hospital care at State expense? Is income the only determining factor, or should the total cost of hospital services be evaluated in determining eligibility?

Can the insurance principle be utilized in solving the problem rather than the current principle of payment for individual cases?

Can contracts be written with Blue Cross or other insurance agencies?

Can the length of stay of State-aided patients be reduced to a level more closely approximating that of general hospital experience, especially in the light of such major social problems as poor housing, lack of domestic help and home nursing service, and the shortage of nursing home beds at reasonable cost?

Summary

The State of Maryland has now had almost a century and a half of experience in rendering financial aid to hospitals for the care of needy patients. Over this period of time the State has accepted the principles of State-aid to voluntary hospitals for care given to persons of low income, preparation of budgets on an objective basis, administration of the program by the Health Department and consultation with the hospitals before instituting policy changes.

The hospitals, on the other hand, have accepted determination of eligibility by a State agency, reimbursement on a per diem basis of less than cost in most instances, and administrative controls over length of stay.

The result has been a program which is mutually satisfactory in broad outline to all concerned.

The major remaining problems of State-aid for the care of needy patients are primarily in social and economic realms rather than in the fields of hospital adminitsration or government-hospital relationships.

R. H. Riley

Director

BALTIMORE CITY HEALTH DEPARTMENT

Certificate of Live Birth Form Revised

On the recommendation of the Committee on Maternal and Child Welfare of the Medical and Chirurgical Faculty of Maryland a revised Certificate of Live Birth was put in use in Baltimore beginning January 1, 1953. The main changes in this form deal with confidential supplementary medical data relating to complications of pregnancy and labor.

The City Health Department's Statistical Section and its Bureau of Child Hygiene feel that the changes will make available much useful additional information on the extent of complicatons of pregnancy, in relation to congenital malformations, prematurity and infant mortality. Studies of this nature are carried on by the City Health Department in cooperation with the Medical and Chirurgical Faculty Committee and it cannot be too strongly emphasized that the validity and reliability of these investigations will be dependent upon the accuracy and completeness of information provided by the attending physician.

Copies of the newly revised Certificate of Live Birth form and explanatory letters have been sent to all the obstetricians in Baltimore, to the Chiefs of Obstetrics Departments in local hospitals and to Directors or Superintendents of hospitals with obstetric services.

The text of the letter sent to the obstetricians is as follows:

Dear Doctor:

Enclosed I am sending for your inspection samples of our newly revised Certificate of Live Birth form. Additional copies of these forms will be sent you under separate cover if you should request them. For these you may write, or telephone the Bureau of Vital Records, Plaza 2000, Extension 833. A supply of the new forms has been forwarded to each hospital in the city.

Please use the new certificates as soon as you have used up any older forms you may have on hand.

There is no change in the first 18 items in the certificate. The main changes are in the Confidential Medical Report beginning with Item 19A. They were made in order to make the answering easier and more accurate. In the new form you will find them on the back of the certificate. Should any problems arise in respect to completion of the Confidential Medical Report, please feel free to call Dr. Janet Hardy, Director of the Bureau of Child Hygiene, Baltimore City Health Department, Plaza 2000, Extension 324.

Your assistance in these matters will be greatly appreciated.

Sincerely yours,

Huntington Williams, M.D.
Commissioner of Health

Any Baltimore physician who performs obstetrics and who may not have received the above letter is requested to notify the City Health Department, Plaza 2000, Extension 324.

Huntington Williams, M.D.
Commissioner of Health

* * * * * *

HEART TRAINEESHIPS

General Statement: The Surgeon General of the Public Health Service has established traineeships in the prevention, diagnosis, and treatment of cardiovascular diseases. The purpose of these traineeships, termed Heart Traineeships, is to improve the competency of the trainee in matters relating to the diagnosis, prevention, and treatment of heart diseases. This Heart Traineeship program is not to be confused with the Research Fellowship Program of the Public Health Service which is intended to promote the development of research workers.

Location of Traineeships: Traineeships may be carried out at any institution where well-rounded cardiovascular training is given. It is the responsibility of the applicant to make all the necessary arrangements with the institution of his choice.

Time of Award and Effective Beginning Date of Traineeships: Applications for National Heart Institute Traineeships are considered for awards three times a year.

Deadline for Receipt of Applications	Date of Review
First of January	First week in February
First of May	First week in June
First of September	First week in October

How to make application: Application forms may be secured by writing to the Grants and Training Branch, National Heart Institute, National Institutes of Health, Bethesda 14, Maryland.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. GEORGE H. YEAGER, *Auxiliary Editor*

A.M.A. PRESIDENT TO SPEAK AT ANNUAL LUNCHEON

Although he is speaking the night before at a dinner-meeting in Iowa, Dr. Louis H. Bauer, President of the American Medical Association, has graciously accepted Mrs. Charles H. Williams' invitation to speak at our Annual Auxiliary Luncheon! Members of the Medical Society are invited, as usual, and, we are sure, will very much want to come to hear Dr. Bauer. Since Maryland has not had a visit from a President of the A.M.A. in more than twenty some years, we can expect a real turn out.

We are sincerely grateful to Dr. Bauer for making such an effort and for taking such a tiring trip for the cause of American Medicine, and more particularly for *us*. Our President, Mrs. Charles H. Williams, is to be congratulated for securing such an honor for Maryland, and for her initiative in inviting the Auxiliary Presidents of surrounding States such as Virginia, West Virginia and Pennsylvania to attend our Annual Meeting for the first time. It should be a wonderful meeting.

ALL-FACULTY BALL PART OF ANNUAL MEETING PROGRAM

This year the first state-wide Auxiliary-Faculty dance will be held in connection with the regular Annnal Meeting program. It has been planned for Monday night, April 27th, so that County members can come to Baltimore for it and stay on for the Tuesday and Wednesday programs with their husbands.

It is to be held at "The Alcazar" from nine until one and will, of course, be formal. Although the dance is planned for all Faculty members and their wives, the work is being done by the Baltimore City Auxiliary. They will use the proceeds to establish a Nursing Scholarship and, towards the state-wide Nurse Recruitment film which they are helping to make, and the American Medical Education Foundation. We can enjoy the evening and the reunion with friends from all over the State, and at the same time contribute to the cause of health education.

THREE "CAN CAN LADIES" OF FOLIES-BARE-GERE

Come see the show and spend an "Evening in Paris" dancing at "The Alcazar"—Monday, April 27, 1953, 9 until 1

MRS. E. ELLSWORTH COOK, JR.
MRS. THEODORE KARDASH MRS. IRVING TAYLOR

CONGRATULATIONS TO NURSES' ASSOCIATION!

Mrs. Albert E. Goldstein, President of the Baltimore City Auxiliary, tells us that she has written to the State Nurses' Association to congratulate them on the Nurse Recruitment Calendar sponsored by the Association and published by a local dairy. The large picture above the calendar shows a pretty nurse caring for a little girl over the slogan "This Could Be You!". Good work by an important part of our health-education team!

DOCTOR'S DAY

MRS. GERALD W. LEVAN, *Chairman*

Guardians of Health

We Americans are so richly blessed with the advantages of modern civilization and have come to depend so entirely on our new inventions and discoveries that we do not give rational thought to the most important service that we enjoy—the medical protection that makes everything else in life worthwhile, and without which we would regress not years but centuries.

Even the thought of being deprived of our telephone, automobile, radio and airplane would throw us into a state of demoralization and panic, but do we appreciate to an equal degree the even greater dependence of civilization upon the services of the science of medicine?

It is regrettable that man of the 20th century takes everything so much for granted and fails to appreciate fully the benefit he derives. In accepting things as they are, he forgets that such pestilences as cholera, yellow fever, leprosy and smallpox ever existed here and is practically oblivious to the idea they could return in a short time, if we did not have the medical profession working constantly to prevent it. Consider what would happen to New York, or any other large city, if it were deprived of this protection. Epidemics would soon sweep across the country wiping out most of the population and our remaining civilization would go back centuries. In times of great disaster, the medical protection ranks in importance scarcely behind that of food supply. So, as we travel the road of life, let us not forget the guardians of our nation's health—the medical men who labor long hours to care for the sick and are constantly and unselfishly engaged in research to prevent human misery and suffering.

Never before have the advances of medical research and discovery affected the welfare of so many human beings. We do not have to resort to cold statistics to know that millions of additional years of living have been given to mankind by its doctors, and that they are healthier years than our ancestors ever knew, because, generation after generation, doctors have pursued their struggle for the prevention of disease and the prolongation of life. The greatest danger to the advance of medicine and the scientific spirit comes not from the masses of unthinking people but from the intelligent people who play such an important role in the shaping of our civilization, but who have not yet been educated to think rationally. And here is where the Woman's Auxiliary to the Medical Societies has a very definite and important role to play, working in the various other organizations of the community in which they live.

Rene Descartes (1596–1650) once wrote this: "If ever the human race is raised to its highest practicable level intellectually, morally and physically, the science of medicine will perform that service." I quote this because it stresses one of the aims of the Auxiliary, namely: "To extend the aims of the medical profession to all organizations in the advancement of health and health education."

America has a stake in her doctors of medicine and rightly she should have, for here we have the greatest number of highly trained and completely devoted group of physicians and surgeons in the world. They are second to none!

Your doctor is a member of "the most humane of all professions" and is also the most human of men—a personal being as well as a professional being. He was once a little boy living just like any other little boy and he grew up, went to school, chose a career, got married, raised a family, worked hard and grew old just the same as other men. His profession knows no language, race or creed for it is consecrated to the service of humanity. His is the profession that cares for life itself, and the medical practitioner is closer to the heart of America than any other group, unless it be the ministry.

The doctor is first of all a citizen—of everyman's world—and is vitally interested in his community. He is not only concerned with the physical symptoms of his patients but also their social, economic and spiritual conditions which so often affect his diagnosis and cure. You will find him generous with both his time and money when it comes to civic affairs, for he is ever working for the betterment of his community. Doctors have always been leaders in health and sanitation just as today they are leaders in civil defense of our nation.

Just as America has a stake in her medical men, so does Maryland. Our state was the 7th in our nation to organize medically, when in 1799 the State Legislature granted a charter and the society of doctors was incorporated. This organization is known today as The Medical and Chirurgical Faculty of the State of Maryland, and has a membership of approximately 2,451. The doctors of Maryland have written a memorable page in the annals of medical science. We are very proud of their notable achievements and contributions to the science of medicine, as well as the part they have played in making our medical institutions so outstanding.

The Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland feel that it is fitting that we give our doctors more deserving recognition than they have had, so we are appealing to the General Assembly of Maryland to enact a Law that will give us a designated day on which we can pay tribute to our medical men.

To a doctor's wife, every day is Doctor's Day and her entire life is devoted to adjustment to her doctor-husband's way of living, but once a year it would be nice to make him feel extra special by honoring him on a specific day. In having a certain day set aside, we hope to impress the laity with the value of the Physician to the Community, and to cause the layman to pause long enough to think how completely and unselfishly the medical profession is dedicated to his welfare. It will be a day on which we are reminded that it is time to say "Thank You," each in his own way, to the doctors of Maryland—the guardians of our health. It never costs much to express gratitude and just to know that somebody is grateful can mean so much.

The date of March 30 is significant. It originated in Georgia, when that state honored one of its famous sons, and is spreading over the country from this state. It is the anniversary of that day in 1842 when Dr. Crawford W. Long of Jefferson, Ga., first used his discovery of ether anesthesia in performing a surgical operation. By honoring Dr. Long's work, we honor all physicians and surgeons. Let us not only thank the doctors as a professional group but let us, individually, thank our own doctor to whom we turn for treatment and guidance.

A BALTIMORE COUNTY PLAN

MRS. MARTIN E. STROBEL, *Past-President*

Due to a limited membership, the Woman's Auxiliary to the Baltimore County Medical Association has concentrated its efforts on three main Committees; namely, Public Relations, Legislation, and Nurse Recruitment. It was felt that more could be accomplished by this method than by having other committees which are not as *important* in operation.

Also, only one main project—which is our Annual Nursing Scholarship—has been undertaken. To raise money for this Scholarship, an annual Doctor's Day Dance has been held. In that way, the dance serves a two-fold purpose.

Perhaps *other* Counties with a small membership might consider such a plan instead of trying to maintain too many different committees inadequately.

MONTGOMERY COUNTY GENERAL HOSPITAL SUPPER AND BAZAAR

MRS. JOHN G. BALL, *President-Elect*

Traditionally, for the past thirty years, on the last Tuesday of July all Montgomery County roads lead to Sandy Spring and the Montgomery County General Hospital Supper and Bazaar. No matter whether the day is rainy, sunny or windy, the Hospital Supper and Bazaar is always held! People come from all over the County and nearly two thousand of them stay for the famous chicken and ham supper prepared by the Hospital Board. On the sweeping green lawn in front of the hospital, tables laden with a variety of articles appear. Fancy work, "white elephants," county store products, homemade jellies, cakes, and goodies.

This year, July 29, 1952, something new appeared among the tables—a table in a choice location with nothing to sell, but something to *give*. The Woman's Auxiliary to the Montgomery County Medical Society set up an exhibit consisting of an electric question-answer box made by the Maryland Society for Medical Research. Three members of the Auxiliary manned the table. They were Mrs. J. Marion Bankhead, Mrs. James Kerr, and Mrs. Charles H. Ligon. Literature ordered from A.M.A. in Chicago to be delivered to Mrs. Ligon in Sandy Spring, arrived in Kensington *and* Silver Spring, but finally, was conveyed to Sandy Spring in time for distribution. The Society for Medical Research delivered and picked up their question-answer box, for which the committee was very grateful.

The members report the greatest interest was shown by young people of high school age. They didn't know why they rang the bell or lighted the lamp, but they wanted to try for a good "score!" Many people couldn't understand some of the questions or the words! Many others couldn't understand why it was free! The literature of the Maryland Society for Medical Research, together with A.M.A. "A Doctor For You," "Socialized Medicine is no Bargain" were distributed. However, we observed that very few questions were asked. We hope that this indicates that rural Montgomery County is well educated health wise and is satisfied with its medical care.

AUXILIARY NEWS

Baltimore County announces its new officers as Mrs. Thomas E. Wheeler, President, Mrs. E. V. Caples, Vice-president, Mrs. John C. Baier, Recording Secretary, Mrs. Hans W. Constadt, Corresponding Secretary and Mrs. Elliott C. Flick, Treasurer.

The Auxiliary to the Washington County Medical Society has elected Mrs. Gerald W. LeVan, President; Mrs. John H. Hornbaker, President-Elect; Mrs. Philip J. Hirshman, Vice-President; Mrs. James W. Sachs, Recording Secretary; Mrs. John A. Moran, Corresponding Secretary; Mrs. Ernest F. Poole, Treasurer and Mrs. Ralph S. Stauffer, Parliamentarian.

* * * * * *

First All-Faculty Dance!

A STATE-WIDE BALL WILL BE PART OF THE ANNUAL MEETING PROGRAM

April 27, 1953

Make reservations now for the "Evening in Paris" Ball to be held on Monday, April 27, 1953 from 9 until 1 A.M. at "The Alcazar" and sponsored by the Woman's Auxiliary to the Baltimore City Medical Society.

Dress optional. Be a "Parisien," be a Patron and be THERE!

Tickets—$3.00 per person, including tax. Please make checks payable to the Woman's Auxiliary to the Baltimore City Medical Society and mail to:

Mrs. E. Ellsworth Cook, Jr.
2431 Maryland Avenue
Baltimore 18, Maryland

Maryland
STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 2 *April, 1953* NUMBER 4

EDITORIAL

THE ROLE OF THE PHYSICIAN IN THE EARLY DETECTION OF CANCER OF THE BLADDER

HUGH J. JEWETT, M.D.*

Cancer of the urinary bladder is sufficiently prevalent, disabling, and lethal to warrant a concerted effort to recognize it in its earliest stages. A survey conducted by the Federal Security Agency of the U. S. Public Health Service disclosed the death rate from this disease per 100,000 population during 1945 to be 10.5 among individuals 55 to 64 years of age, 26.2 among individuals 65 to 74, and 49.4 among individuals 75 to 84. The ratio of males to females was 2:1.

Etiological mechanisms now under suspicion are for the most part purely conjectural. The identification of the specific carcinogenic activity of B-naphthylamine, a compound used in the chemical industry, has stimulated speculation concerning possible causes of non-occupational bladder tumors in the general population, but proof of carcinogenicity for the bladder of other compounds has been lacking in clinical practice. Some tumors very probably result from persistent irritation of the vesical mucosa.

The tumor may commence either as a minute projection of epithelium surrounding a core of connective tissue containing a blood vessel, or as a focus of anaplasia within the vesical mucosa itself. In either event malignant cells finally break through the underlying basement membrane and invade the bladder wall and its lymphatics and blood vessels. Metastases to retroperitoneal lymph nodes, liver, lungs, and bones are common when the tumor has infiltrated deeply into the muscle layer of the bladder, and the prospect for cure by surgery diminishes as the extent of infiltration increases.

The rapidity with which a carcinoma can infiltrate the wall of the bladder bears some relation to the degree of anaplasia of its cells. Undifferentiated tumors may extend through the wall in a few weeks, whereas well differentiated tumors may require several months. *Recognition of a tumor within a short time after the onset of symptoms therefore becomes a matter of considerable importance to the patient.*

The cardinal symptoms are hematuria and frequency of urination. In a group of 73 cases of cancer of the bladder in which complete study had excluded other urological disease as a possible cause of the symptoms, 65 patients had complained of blood in the urine. In 7 of these the hematuria was at the end of urination, and in 2, at the beginning.

---

*Editorial Board, Maryland State Medical Journal.

In 6 additional cases erythrocytes were found only by microscopic examination, so that 71 of these 73 patients had hematuria of varying degree. Fifty-five of the 73 patients complained of frequency, but the urine was reported to contain bacteria in only 17.

As a rule a patient complaining of hematuria with or without frequency consults his family physician first. Since blood in the urine is known to occur in many conditions other than cancer, the temptation to temporize may be strong. However, *bleeding usually is the earliest and most characteristic symptom* of malignant disease of the urinary tract, and even if transient or painless its degree is no reliable guide to the gravity of the situation.

At present, exfoliative cytology (stained smears of the urinary sediment) and biologic tests for malignancy are of no practical value to the physician in the early detection of cancer of the bladder. But his insistence upon immediate and definitive investigation makes possible an early diagnosis in a high percentage of cases. When the tumor is found to be small and superficially infiltrating, surgical removal provides a 5-year survival rate of 83 per cent. When symptoms occur late or are neglected, tumor cells generally have had time to reach the deeper layers of the bladder, and the 5-year survival rate even after total cystectomy is only 10 per cent.

UNITED STATES MEDICAL AND DENTAL ACADEMY

THE AMA WASHINGTON LETTER NO. 7, FEBRUARY 13, 1953

H. R. 2718 (Heller, D., N. Y., Feb. 6). Would create a medical and dental school for physicians and dentists of the armed services and the Public Health Service. Four students would be selected from each Congressional district and each territory, six from the District of Columbia, four from Puerto Rico, two from the Canal Zone, eight from each State, and one-hundred thirty-two from the United States at large. Each Senator and Representative would be entitled to have four of his appointees in the school at all times. Course of study would be such as prescribed in "responsible and recognized medical and dental schools." (A similar bill by the same author last Congress provided that the course of study be prescribed by the American Medical Association and listed subjects to be included.) Upon graduation students would be commissioned in the armed services or the Public Health Service as needed and could be required to stay in such service for at least 5 years. In direct charge of the Academy would be a Superintendent to be appointed by the President with the consent of the Senate. Matters of policy, including the number of instructors and courses of study, would be decided by the Secretary of Defense and the Surgeon General of the Public Health Service, upon recommendations by the Superintendent. A Board of Visitors would include 5 persons appointed by the President, 3 of whom at least shall be outstanding in the fields of medicine or medical research. *To Interstate and Foreign Commerce Committee.*

HONORING "OUR GUS"

After a long and "faithful" service to the medical profession in Maryland, it seemed most appropriate that recognition was taken of a valued employee, Gustave Orville Caution.

At the meeting of the Baltimore City Medical Society, Friday, February 20, 1953, the Medical and Chirurgical Faculty and the Baltimore City Medical Society presented Gus with appropriate resolutions and monetary gifts. The State Board of Medical Examiners previously had given him a humidor, pipe rack and pipe.

The Editor of the Journal believes that the ceremony honoring Gus is of interest to all the members of the Medical and Chirurgical Faculty and therefore the following is published in detail:

Dr. Wetherbee Fort:[1] Dr. Chatard and Dr. Kloman, will you please come up to the platform?

The next order of business is a very pleasant one. We are going to honor a member of our cast who has been performing in a magnificent way for us all for many many years.

February twentieth, fifty-six years ago, a slip of a lad, Gustave O. Caution—better known to us as "Gus"—was employed temporarily by the late Miss Marcia C. Noyes, Librarian and Executive Secretary. To the best of anyone's knowledge he has never actually been formally employed by either the Medical and Chirurgical Faculty or the Baltimore City Medical Society. He has just stayed on and we put up with him.

So tonight both organizations felt that it would be only right and proper for each to present "Gus" with a little present and a testimonial.

Walter, will you please bring "Gus" to the platform?

(IS ESCORTED TO THE PLATFORM WHILE AUDIENCE APPLAUDS)

Dr. Fort: I will ask Dr. Chatard to make the first presentation.

Dr. J. Albert Chatard:[2] It seems to me that only a few years ago I did very much the same thing for Miss Noyes.

"Gus" has been with us fifty-six years. He has been with us long and knows us all well. I want to say a few words to him before I read a resolution; that he is right in the midst of his friends. Some of them may be very young; some of them may be middle age; some of them may be quite old; others may be absent in the City or State. They are still his friends, and particularly on the walls, "Gus" there are a lot of your friends.

Gus Walter

Gus being escorted to the platform by his son, Walter Caution

Now I just want to say these few words because I have known "Gus" for fifty years. Over half a century has gone by but the fifty-six years have changed your activity very little. You still have the small, dapper figure you have always had; the smile is there at all times. The hair a little thinner and both it and the mustache a little grayer, but your activity a marvel to all of us as we hear the "feet patter" about as before.

Your great-great-grandfather, Samuel Caution must have come to this Country as a French citizen about the same time my great-grandfather Pierre Chatard came here also, hence, I can understand your courteous, gentlemanly French manner which you have never lost.

---

[1] President, Baltimore City Medical Society.

[2] Treasurer, Medical and Chirurgical Faculty.

The words in our resolution are helpful as a reminder to you of our thoughts. Within our hearts there is more the feeling that you are not in the class of the forgotten man.

Personally, I want to thank you, "Gus," for all the years you have been so thoughtful of me. Your smile I cannot forget and your gentlemanly manner illustrates so well the old saying "Manners maketh the man." All best wishes, "Gus," for many, many more years with your family and friends both in and out of the Medical Profession.

Now I will read the resolution. This comes from the Medical and Chirurgical Faculty. There will be resolutions from the City Society as well as the State Board of Medical Examiners:

Whereas, Gustave Orville Caution has been a faithful and diligent employee of the Medical and Chirurgical Faculty of the State of Maryland for the past fifty-six years, and

Whereas, during that continuous duty at all the functions of the State Society, he has shown remarkable activity at all times and efficiency in dealing with the many problems presented, and

Whereas, his personal knowledge of so many of the very old and younger members and his recognition of them "in the dark," helped them with their sick calls during the meetings, therefore, be it

Resolved, that our members record their appreciation of this service by "one small man" for so "many," always with his smile as he patted about the various duties assigned to him, and be it further

Resolved, that a copy of this Resolution be spread on the Minutes of the next meeting of the Council of the Medical and Chirurgical Faculty, and be it further

Resolved, that a copy of this Resolution with the honorarium be given to Gustave Orville Caution as evidence of our sentiment and regards, with all best wishes for many more years of a happy life.

Maurice C. Pincoffs, M.D., *President*
George H. Yeager, M.D., *Secretary*
J. Albert Chatard, M.D., *Treasurer*
C. R. Edwards, M.D., *Chairman of the Council*

Dr. Fort Dr. Kloman Gus Dr. Chatard

Gus registers joy and gratitude upon receiving the gifts and resolutions

(PRESENTATION TO "GUS" AND TREMENDOUS APPLAUSE)

Dr. Fort: Thank you, Dr. Chatard. Now I will ask Dr. Kloman, President of the State Board of Medical Examiners, to read his resolution.

Dr. E. H. Kloman: We of the Board, want to say everything that Dr. Chatard said to you, and I won't take the time in repeating it.

I want to read this resolution—but we were afraid we wouldn't be here tonight so we gave "Gus," two or three days ahead of time, the little token referred to in the resolution.

WHEREAS, Gustave Orville Caution has been a faithful, diligent employee of the Medical and Chirurgical Faculty of the State of Maryland for the past fifty-six years and

WHEREAS, during that long period he has been a ready, willing, cheerful, assistant to the Board of Medical Examiners, not only during the examination sessions, but whenever his services have been requested. He has been, indeed, a "Minute Man" in his promptness and efficiency in performing the tasks assigned him, and has earned the affectionate good will of all the members of the Board by his deep loyalty to them and to the Board, therefore, be it

RESOLVED, that this Board record its appreciation of the friendly interested service of our friend "Gus," and our high personal regard for this kind, courteous gentleman, and be it further

RESOLVED, that a copy of this resolution be given to Gustave Orville Caution and that the Board of Medical Examiners of Maryland present him with this Humidor as a token of our sentiments and regard.

ERASMUS H. KLOMAN, M.D.
LEWIS P. GUNDRY, M.D.
SAMUEL MCLANAHAN, M.D.
JOHN E. LEGGE, M.D.
HENRY T. COLLENBERG, M.D.
E. PAUL KNOTTS, M.D.
EDWARD P. THOMAS, M.D.
JOHN H. HORNBAKER, M.D.

(APPLAUSE)

DR. FORT: I don't know whether you understood fully what Dr. Kloman said about what the Board gave Gus. It was an appropriately engraved humidor, pipe rack and pipe.

My remarks may not be as eloquent or the choice of words as grand as Dr. Chatard's, however, they will be right from the heart and just as sincere. There is one thing that is certain, I can top Dr. Chatard in one detail. I have known you two years longer than Dr. Chatard. This is not difficult to figure despite the difference in our ages—not yours but Dr. Chatard's and mine, because my father who was an ardent reader and a member of this Society used to bring me as a kid six or seven years of age to the old library building when he wanted you—we didn't call them baby sitters—to take care of me while he was reading. And if I remember—my figures bear me out—that takes us back to 1903, which is about fifty-two years ago.

So, with the reading of this resolution, "Gus," I want to present you also with a little token of our esteem.

WHEREAS, Gustave Orville Caution has been associated with the Baltimore City Medical Society for fifty-six years,

DR. KLOMAN DR. CHATARD GUS DR. FORT

Gus expresses to the members his thanks and appreciation of the honor given him having entered the employment of the Medical and Chiurgical Faculty on February 20, 1897, and

WHEREAS, Gustave Orville Caution has, during that long period, served the Baltimore City Medical Society with distinction, and

WHEREAS, by his efficiency, loyalty, industry and unfailing courtesy, and by virtues which characterize him as a true gentleman, has endeared himself to the members of the Baltimore City Medical Society.

NOW, THEREFORE, BE IT RESOLVED, that the Baltimore City Medical Society at a meeting held on February 20, 1953, extend its hearty congratulations to Gustave Orville Caution with sincere good wishes for many more years of usefulness and happiness, and

BE IT FURTHER RESOLVED, that the Baltimore City Medical Society present to Gustave Orville Caution a token of its appreciation of his fifty-six years of faithful services, and

BE IT FURTHER RESOLVED, that this Resolution be spread upon the Minutes of the Baltimore City Medical Society and a copy thereof presented to Gustave Orville Caution.

WETHERBEE FORT, M.D., *President*
LEWIS P. GUNDRY, M.D., *Vice-President*
EDWARD F. COTTER, M.D., *Secretary*
ROBERT C. KIMBERLY, M.D., *Treasurer*

(PRESENTATION AND APPLAUSE)

GUSTAVE ORVILLE CAUTION: I want to thank Dr. Fort, Dr. Chatard, and Dr. Kloman and all the rest of the Faculty members for their courtesy toward me, and I appreciate the things that they have done for me at present and in the past.

I have tried to be faithful to you gentlemen ever since I came with the Faculty, as Sir William Osler who is dead now told me when I came to the Faculty, to be faithful to the Faculty and they would be faithful to me. I appreciate you gentlemen one and all for your faithfulness and I tried to do my service and will continue to do so if the Lord spares me. Thank you.

(AUDIENCE APPLAUDS IN OVATION)

DR. FORT: I would say that "Gus" is a very good speechmaker.

The Baltimore Evening Sun, on Friday, February 20, 1953, published an article on Gus together with his picture.

When Gus was with the Medical and Chirurgical Faculty fifty years, the Association had a brief ceremony during its Annual Meeting and gave him a substantial check.

On behalf of the entire Medical and Chirurgical Faculty, we wish to thank Gus for his services to the profession, during these many years, and hope he will continue to carry on his duties in his inimitable way and to be in the cloakroom, taking care of the hats and coats of the members, for many years to come.

HAVE YOU PAID YOUR A.M.A. DUES?

If not—and you wish to attend the meeting, mail your check to the Faculty Building but make it payable to the American Medical Association.

For the first time in many years, the Annual Meeting of the American Medical Association is being held in New York City, June 1–5, at Grand Central Palace. More than 15,000 physicians are expected to register, and about 30 other conventions will be meeting in New York City at about the same time.

Most important—**physicians will need a 1953 A.M.A. pocket card** to admit them to the Scientific and Technical Exhibits, as well as to the sectional meetings.

Scientific Papers

PANEL DISCUSSION: DIETS*

Dr. Samuel McLanahan, President: We will now turn to the scientific discussion having to do with a panel on diets. There are blank papers in the seats for the purpose of preparing questions and it is hoped questions will come from the audience.

I will introduce briefly the participants in this panel.

The Moderator for our panel discussion of diets comes from Boston. We appreciate the distance that he has come and his preparation for this panel. Dr. George V. Mann is Assistant Professor of Nutrition, in the Harvard University School of Public Health, Boston, Massachusetts, and Assistant in Medicine at the Peter Bent Brigham Hospital. Dr. John Eager Howard, Associate Professor of Medicine, The Johns Hopkins University Medical School; Dr. Nicholson J. Eastman, Professor of Obstetrics, The Johns Hopkins University Medical School; Dr. R. C. V. Robinson, Instructor of Medicine, The Johns Hopkins University Medical School and Assistant Professor of Dermatology at the University of Maryland Medical School; and Dr. E. Cowles Andrus, Associate Professor of Medicine, The Johns Hopkins University Medical School.

Dr. George V. Mann (Moderator): Dr. McLanahan, Ladies and Gentlemen, I am honored by this invitation to appear at the Baltimore City Medical Society meeting. I am perhaps a little overwhelmed by the distinction of the panel members sitting beside me. As some of you know, a few years ago I was a student of most of these people.

I would like to make perfectly clear my roll in the proceedings this evening. We have a relatively small group here in the audience, which should be an advantage for all of us because it will allow a good deal of participation. We are above all interested in practical matters and will try to minimize the theoretical aspects of science and nutrition and to emphasize the application of nutrition to pertinent medical problems.

Each member of the panel sitting here, as you recognize, has some particular specialty or interest in medicine, and each I'm sure has a wealth of experience and information to contribute to the problems to be discussed here tonight. We are not going to be able to discuss all aspects of diet as applied to medical problems. We will try to select—and it will be a somewhat arbitrary selection—certain of the problems which it seems are pertinent.

By way of an introduction, and in order that the panel may indicate in some way to you their particular interests, each participant will make some opening remarks to serve as a focus for your questions. Dr. John Howard will start with a discussion of obesity. Obesity perhaps more than any other problem deserves emphasis in a medical meeting because it can be said without qualification that obesity is the most prevalent nutritional disorder in this country. Furthermore, I doubt if there are any other nutritional problems for which we have as few really adequate and workable answers. I hope that some of these questions, perhaps unanswerable it is true, will be posed to this group before the meeting is closed. In the meantime, I would like Dr. Howard to give us some background for the discussion.

---

* Presented before the Baltimore City Medical Society on Friday, November 21, 1952, at the Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore 1, Maryland.

OBESITY

JOHN EAGER HOWARD, M.D.

I fear that there will be nothing new to you in my remarks tonight on the subject of obesity. Despite the intricacies and interrelationships of the chemical mechanisms in the anabolism and catabolism of carbohydrates, fats and proteins, one still cannot circumvent the laws of energy conservation; and a person who gets fat must take in more than he expends. Contrariwise in the process of weight reduction, the accounts must show a negative balance—a greater expenditure than intake of energy. This assumes, of course, that when one is speaking of weight loss or gain, the reference is to tissue; and in the subject under discussion, our reference is to excess adipose tissue. The scales often play us false and disclose water losses from the intra- and extracellular body compartments—a fact which accounts for the continued preying upon the public by multitudes of fake obesity cures involving sweating and diuretic agents; but the regimens of this type which show any lasting results are always accompanied by dietary restriction (of energy intake).

Perhaps it would be well here to remind you of the wide variation that occurs when individuals are restricted in their caloric intake. Most persons will, of course, lose water, rather rapidly at first, due largely to the fact that endogenous protein catabolism has been increased (to supply the energy deficit some protoplasm is consumed as well as stored fat) and there is coincident urinary loss of intracellular electrolyte and water. The scales will show in the first week a five or even a 10 lb. weight loss—to the elation of the unwary dieter. Subsequent weeks will show much lesser losses of poundage and some no loss at all, or even small gains.

There are also some individuals who will lose no weight whatever, even on the most perfectly organized reduction dietaries, for two weeks or more. There will then follow a sharp weight loss; and at the end of a month or two, both types of individuals—i.e., the early fast losers and the slow losers—will be found to have adjusted their water equilibria to the new metabolic situations and both will have yielded about the same poundage. The point to be remembered is that the desired end in the treatment of obesity is to lose the excess *fat.* To accomplish this, the fat must be metabolically burned. Since fat is a high calorie foodstuff and yields approximately 9 calories per gram; and since from a practical point of view one can, in reducing regimens, only allow a deficit of about 1000 calories to be made up by body fat (a point to be discussed later), and since fat depots hold very little water (in contrast to protein and carbohydrate depots)—it may be seen that only about *100 grams of fat* can be burned off each day. Thus if we "reduced" in ideal fashion, that is, lose nothing but fat in the process and conserve all our substance (muscle, visceral protein, etc.), we should lose only 700 grams per week, or about 1½ lbs.

We cannot so regulate a diet, however, that in weight reduction of any magnitude some protoplasm (presumably useful) will not be coincidently lost; but in planning a campaign to lose weight, it will be well to keep in mind that an average over the months of 2 lbs. per week is all that can be achieved without loss of tissues that one doesn't care to lose. The points to be emphasized are recognized by all who are experienced in treating obese persons, namely, that but little fat can be burned per day in terms of poundage, and that the frequently practiced daily examination of the scales reflects only water balance, leading to short-lived euphoria in some and depression in others. It is a wise rule to insist on weighing at intervals of two weeks to one month, for thus the inequities of water metabolism will be smoothed out, and the menstrual water fluctuations will likewise be eliminated from the picture.

Before discussing more specifically the quantitative and qualitative aspects of dietary regimens, it would perhaps be wise to look briefly on what is known of the *etiology* of obesity. The negative aspects of this subject seem more clear than do the positive.

So far as we are aware, there is no basis in scientific fact for the still commonly held notion that uni- or multiglandular dysfunction is primarily responsible for the development of obesity, with the possible exception of Cushing's syndrome and hyperinsulinism. One cannot experimentally remove any gland or glands, nor can one inject any combination of glandular extracts, and thereby produce obesity in the sense that we are using the term. Hypothyroidism and myxedema are almost never associated with any real degree of obesity; in fact, when one sees a really fat person, underfunction of the thyroid can be practically excluded. This dictum has been so frequently reiterated that it seems astonishing that thyroid is still so frequently administered for the purpose of weight reduction. For it never accomplishes the desired end, since if small doses are used the patient's own gland functions just so much less and euthyroidism is maintained; whereas if intoxicating doses are prescribed, either unpleasant symptoms occur or body protein is excessively wasted or both. Weight loss from undernutrition is, of course, accompanied by a lowered basal metabolic rate and perhaps by reduced thyroid function, but this is a physiological adaptive process and had best be left uncorrected.

Pituitary insufficiency became connected with obesity in the minds of physicians because of its occasional association with destructive tumors in the hypophyseal area; and this was abetted by the observation of the early experimental brain surgeons that *some* of their hypophysectomized animals became enormously fat. It now seems clear that coincident lesions of the hypothalamus are responsible for these so-called "pituitary obesity" cases. The legitimate term "Frohlich's syndrome," which is in reality a quite rare condition, has been so much misused and has for so long erroneously carried with it the concept of hypophyseal insufficiency as the cause of obesity that the term had best be dropped.

Experimental obesity has been regularly produced in several physiological laboratories by bilateral puncture of a very specific area in the hypothalamus. Though the metabolism of such animals has not been absolutely defined during the period of rapid weight gain and after the enormous obesity has been attained, it is evident that the major factor is the excessive appetite induced by the lesion. Operated rats, when allowed only the same quantities of food as eaten by their unoperated litter mates, do *not* become fat. The spontaneous and hereditary obesity in the strain of mice identified at the Bar Harbor Laboratories, though not of so severe a degree usually, seems to have much the same characteristics; but so far as I am aware, no specific hypothalamic lesions have been identified in this family of mice, about one-fourth of whom spontaneously weigh three or four times as much as their brothers and sisters if given a little more food to eat than the others naturally consume.

Certain features of these experimentally and hereditarily obese animals are worthy of comment. The excess weight is found to be entirely fat, the carcass weight being the same as that of litter mate controls. They are exceedingly prone to diabetes and degenerative renal disease, and their fertility is very low. Similar pathological tendencies are exhibited by obese humans, as evidenced so dramatically by life insurance statistics.

Obesity certainly does run in families, and whether this is due to an hereditary component in their hypothalami or simply an environmental result of early exposure to faulty habits of eating is not known. The striking frequency with which childhood obesity begins following a tonsillectomy, appendectomy or an acute exanthem also gives food for thought. Has the trauma been purely an emotional one or has there been a coincident anatomic or physiological change in the "appetite center" of the hypothalamus? In this connection the psychiatric problems of the obese are also worthy of further investigation. Early in our interest in obesity, we were fortunate to have the collaboration of Drs. Diethelm, Rennie and Booth. In a study of some 30 fat persons, *all* were found to be suffering from severe emotional disturbances. This uniformity of association seemed more than coincidence; and, regardless of which pathological situation was the cart and which one was the horse, it became very obvious that in most instances such cases are better handled by the collaboration of an internist and a psychiatrist.

Whatever may be the primary defect which results in great weight gain, the only way we now have of attacking it is by dietary restriction. And so far as we now know, every case of obesity is amenable to this form of therapy, though the obstacles to success may often be exceedingly difficult to overcome. I once had a lady tell me, with a perfectly straight face, that she couldn't possibly lose weight by dieting since she had observed that during a round of golf she had gained more than 3 pounds without ever eating or drinking anything at all. One wondered how foggy or rainy a day it must have been for her clothes to absorb so much moisture.

Most persons lose weight exceedingly well if put on a 1400–1500 calorie diet in the Metabolism Ward of a hospital where strict and exact observations of intake can be maintained. It has long been the custom to make such diets high in protein (100 grams or more per day), mainly for the satiety value of this form of food but also with the idea of losing minimal quantities of body nitrogen during the period of weight loss. But Evans and Newburgh and others have used much lower diets containing only 500–800 calories with success and with relatively small nitrogen wastage, at least after the first few weeks. It has seemed to us that the qualitative and quantitative nature of the diet (within limits, of course) are relatively unimportant features of the reducing regimen; that full understanding by the patient of the nature of the problem involved, his complete cooperation and the knowledge that small weight loss over a long period of time is the only possible harmless way—these are the essentials for success.

There are a few tricks, gleaned from experience, that may be worth noting. For some unknown reason, better results are achieved if the total caloric intake is divided into three even partitions, rather than having the patient eat a tiny breakfast and lunch in order to have a big dinner at night. It is remarkable how many obese persons follow the unbalanced intake method instinctively, and experimental evidence from rats indicates that food eaten all at a sitting tends to greater weight than if the same total quantity is consumed at three or four sittings.

One must watch out for alcohol. Many persons forget that the caloric value of alcohol is 7 calories per cc., so that 3 ounces of whiskey yield 315 calories. The "drink or two" before dinner not only adds dietary fuel, but usually also enhances appetite and removes inhibitions.

"Appetite killers," such as benzedrine or dexedrine, have been advocated as adjuvants to dietary regimens. They are also used for the emotional lift in relieving depression and to boost morale for dietary maintenance. It has not been our practice to use these drugs (and no collaborating psychiatrist so far has recommended them for any of our patients). In reality they are crutches to lean upon, and it is usually wiser to face and work out the long-term problem squarely.

It is unwise to yield to the plea: "Doctor, can't I diet six days a week and take a holiday on the seventh?", much like the Lenten Sunday. Experience has taught that this system is far harder on the patient, and Sunday's overeating plays havoc with the adjusted metabolism as well as the emotional pattern of the dieter.

There is no rationale for restricting either fluid or salt in an obesity regimen unless such is indicated by some complicating cardiac or renal disease. Nor has it ever been clear to me why antidiuretic hormone of the posterior pituitary is given to help lose weight. Sweating procedures, widely used by boxers and wrestlers to meet certain weight deadlines, obviously have no place in the subject here under discussion. Actually the amount of calories so expended is exceedingly small, and the excess appetite engendered by the procedure usually more than negates its value.

Carefully outlined postural exercises, however, are often of great benefit. Great obesity is almost always accompanied by faulty body mechanics, especially lumbar lordosis with tense back muscles and weak abdominals and glutei. Correction of such postural defects reduces the waistline, promotes erect carriage and gives such a sense of increased well-being and assurance that it is highly recommended whenever feasible. Whether really true or not, I cannot say; but it has seemed to us that, when weight is being lost by dietary means, coincident development of weak muscles of the abdomen and pelvis has seemed to make the fat come off these areas more freely. Certainly our ultimate best results from the artistic point of view have been those patients who have exercised under the trained eye of Mr. Kendall at the Children's Hospital School.

Lastly a word about preparation of the diets. It has already been mentioned that protein should be a large constituent, fat and carbohydrate relatively low. The protein of shellfish—lobster, crab and shrimp—is ideally suited for such a purpose, being exceedingly low in fat, in contrast to most good lean meats which contain 15–20% of fat. But most important of all, the diet must be suited to the patient, both from the standpoint of palate and pocketbook. Here the services of an expert dietitian are invaluable, and I gladly confess that any measure of success my patients may have had in their efforts to lose weight has been largely due to the expert dietary assistance which it has been my good fortune to have. All that I have had to do was to provide caloric figures and distribute them between carbohydrate, protein and fat; the dietitians in turn have translated them for the patients into palatable available food with reasonably high satiety value. Diet menus may be obtained in almost every movie magazine or ladies' journal, and in themselves they are usually well rounded and contain adequate vitamins. But they suit only the individual for whom they were designed, the menu soon palls on any other.

The latest wrinkle in "obesity diets" has come out of a sister city to the north. The basis of this is to eat a lot of fat, on the ground that the carbohydrate metabolism of the obese individual is so "set" that ingested carbohydrate goes much more to fat than in the normal person. Though I have had the privilege of reading the outline of this as yet unpublished (in detail) thesis, the basic physiological concepts did not to me seem to be consistent with the known facts. However, the diet, which consists mainly of lamb chops and high grade Western steaks, seems to achieve its purpose in bringing about weight reduction. But, when one calculates the intakes of the reported cases, it is found that these individuals have consumed about 1400 calories per day and lost on an average 2 pounds per week—just as have others on the more usual types of diets prescribed for many years. So no new metabolic or chemical theory need be evolved to explain the results obtained.

In looking back over these remarks on obesity, I find that most space has been given to matters other than dieting. And perhaps this is the correct perspective; because, although dietary restriction is the keystone of the weight reduction regimen—at least in the present state of our knowledge—other factors than the prescribed diet are usually the cause of therapeutic failure. The successful regimen must be planned for the total individual, his emotions, his pocketbook, his palate; and if you are fortunate enough to have the collaboration of a dietitian, a physiotherapist and, if need be, a psychiatrist, your chances of achieving success for the patient will be greatly enhanced.

Dr. George V. Mann: One thing is perfectly clear to me, Dr. Howard's cut at 300 pounds to discriminate between those who are obese and those who aren't is a considerably rougher cut than we make in Massachusetts. Perhaps we can come back to this point later because—all levity aside—there is a very important point involved; the question of the change of body composition with age which may not be reflected in a greater girth or even in a greater weight on the scales but which is nonetheless a form of obesity. Let's leave that for a little later and turn now to Dr. Eastman. Continuing in the vein of the problem of obesity, he will discuss some of the practical issues which arise in the management of pregnancy as influenced by the presence of obesity.

OBSTETRICS

NICHOLSON J. EASTMAN, M.D.

Dr. Mann, Ladies and Gentlemen.

A number of studies have shown that women who weigh over two hundred pounds do less well in pregnancy than women who weigh, let us say, 140 or 150 pounds.

An analysis of those series of obese women will usually reveal, however, the following facts:

1. The average age of those patients is higher than the age of the child-bearing population at-large.
2. The average parity of those patients is greater than that of the average child-bearing woman.
3. The incidence of hypertension and of diabetes is higher than obtains in the child-bearing population-at-large.

Accordingly the poor results, the higher maternal and the perinatal mortality rates which have been reported for these obese women are attributable in part to these factors: Age, advanced parity, hypertension and diabetes. Nevertheless, in addition to these factors, obesity per se exerts a deleterious effect in the course of pregnancy and labor in several ways.

In the first place, the obese gravida is a poor anesthetic risk. Most women at delivery have some form of anesthesia and that question inevitably presents itself. For instance, last Spring, we had a five-feet-two patient who weighed 343 pounds. She had a contracted pelvis and a cesarean section was mandatory. The anesthesia in that case was the main problem, as it often is in many of these obese women.

Over-weight women usually have pendulous abdominal walls. This pendulous abdominal wall allows the uterus to fall forward so that the long axis of the baby is not on a line with the pelvic axis, as it should be, and consequently, the head is not directed accurately into the pelvis. Hence, it is likely to be pushed to one side or the other and as a result of these circumstances, the incidence of abnormal presentations is somewhat higher in these obese women.

In addition, it is believed that uterine inertia and other difficulties in labor are somewhat more common. Accordingly, any obstetrician views with some misgivings, women who come to him weighing 250 or so and is more fearsome of the outcome than in the woman who weighs 130 or 140 pounds. As a consequence, efforts are made as a rule in very obese women to reduce their weight during pregnancy, and in moderately obese women to forestall the usual weight gain which usually occurs in gestation. This often means dietary control by a competent dietitian.

For instance, some years ago I had a patient about twenty-two who weighed 258 pounds early in pregnancy. The dietitian managed to keep her content and happy yet reduce her weight to 220 pounds. At birth everything went quite normally and she gave birth to a nine pound perfectly normal baby. We use no medication in these cases, as a rule, but depend on dietary control.

Now, obesity is one thing and excessive weight gain in pregnancy is another. The situation I have been talking about is that of the woman who presents herself weighing from 200 to 300 pounds at the onset of pregnancy.

Excessive weight gain in pregnancy, that is, an increase of weight in a patient who starts pregnancy at 120 pounds and goes to 160 pounds is a different problem, although the management of it may be somewhat similar. If the weight of the baby, placenta, amniotic fluid, uterus, increase in the size of the breast, etc., are added up, a figure of something like thirteen pounds will be obtained which might be referred to as tangible weight gain. This is understandable. But when you recall that the average weight gain of pregnancy is twenty-four pounds, the question arises: What accounts for this additional ten pounds. It may be in some part fat, but it is chiefly water, as evidenced by the very pronounced weight loss which occurs in the early days of the postpartum, associated with nightsweats and a profuse diuresis. Accordingly, when weight gain, especially sudden weight gain occurs in pregnancy, we are inclined to interpret it as waterlogging of the body. One of the purposes of prenatal care, of course, is to detect any evidence of the onset of the toxemias of pregnancy, such as edema, hypertension and albuminuria. Insofar as edema is concerned, the weight gain of the patient is the most valuable index of latent edema.

Obstetricians try to restrict weight gain to about twenty pounds. Indeed, some authorities feel that this should be kept as low as sixteen pounds. In any event, it suffices to say that an attempt is made to keep weight gains down to a figure well under the average of twenty-four pounds; and it is my own feeling that efforts in that direction have resulted in a decided reduction in the incidence of the toxemias of pregnancy. Patients who gain less are freer from the usual complaints of leg ache, backache, and cramps in the latter part of pregnancy. This is to be expected since these complaints are due largely to the fact that those women who gain excessively have to lug around these additional pounds. Gravidae who gain less do better in labor; they get their strength back sooner; and they also get their figure back sooner.

Time does not permit us to go into the ways and means of curtailing weight gain. It means often constant vigilance in the management of these cases together with encouragement. But when a patient, despite all reasonable advice still gains, chief dependence is put on meticulous management in the hands of a competent dietitian.

Dr. George V. Mann: Let us leave the question of obesity for a moment now and turn to Dr. Robinson and his specialist's approach to another aspect of diet and disease.

Dr. Robinson will outline for us some of the pertinent problems in the field of Dermatology. I think particularly the things that we are interested to hear from him, and the questions of food allergy and its manifestations on the skin and some summary of the nature of that problem.

DERMATOLOGY

R. C. V. ROBINSON, M.D.

The concept that ingested foods may cause skin eruptions is not new. For many years, patients have presented themselves to physicians with the complaint that certain foods did not agree with them, causing hives or eczema. These claims were usually belittled or ignored completely. Even today the vast majority of the medical public refuse to believe that the skin may break out after eating anything.

During the past ten years, an increasing number of dermatologists and allergists have become interested in food allergy as a cause of various abnormal body responses. Figley and Rawling (1), in a symposium on the subject, state that "Food allergy is a clinical reality responsible for allergic rhinitis, asthma, urticaria, atopic dermatitis, and, less frequently, headache and gastrointestinal symptoms."

The antagonists of food allergy claim that either the phenomenon does not occur at all, or, if it does occur, the incidence is so slight as to be disregarded. They point out the high percentage of good therapeutic results without curtailment of diet and the failure of patch, scratch or intradermal tests to prove specific sensitivity to any one food. They have also suggested that it might be dangerous for someone not adequately trained in nutrition to curtail the diet of any individual patient for fear of causing serious nutritional disturbance.

It is true that frequently, by the judicious use of local medication and/or x-rays, remissions may be obtained. However, as every dermatologist knows, eczematous eruptions are prone to recur, and there comes a time when further x-ray therapy of any individual's skin is contraindicated. In such cases, even the most adamant die-hard should be willing to give elimination diets a trial.

There is almost universal agreement that skin testing is of little or no value in determining specific food allergens. Circulating antibodies have not been isolated, and one allergist (2) has stated that "Skin tests to foods, even when found positive . . . rarely indicate specific clinical sensitivity." This same author, who incidentally, is not convinced that food allergies cause important clinical entities, has noted that the emotional state of the patient may modify the skin reactivity.

Handled properly, the elimination diet never puts the patient in danger of nutritional disturbance. Even the most drastic basic diet is never maintained long enough to cause deficiencies. In most instances the offending substances prove to be non-essential, and, even if an important food item such as wheat, milk or egg, is found to be the allergen, there are adequate substitutes or supplementary substances to overcome the defect.

What evidence is there on which to base belief that food allergy does occur? Winston and Sutton (3) felt that foods were responsible for 30 of 388 cases of chronic, lichenified and excoriated, non-vesicular eruptions. Livingood and Pillsbury (4) agreed but added another 8 to 10 per cent in which diet was an important contributory factor. Flood (5) was able to prove definitely that ingested food allergens were responsible for fourteen of 65 hand eczemas, and suspected seven more. To those of us who believe in food allergy, proof lies in remissions obtained on withdrawal of a food and exacerbations when the same food is again added to the diet.

How is the offending food isolated, if no specific tests are of value? The only method of value is by a process of elimination. This may be done in several ways. A patient may be given nothing but milk for 48–72 hours. If the condition improves, a food or group of foods is added to the diet every day or two days. If the condition does not improve, the patient is given all foods but milk. This is not a good method since, in one series, 24 of 26 patients were found to be sensitive to two or more foods.

To remove one food at a time from the diet is obviously not practicable. A better method, but one which usually requires hospitalization, is the use of one of the so-called basic diets, in which the patient is given only a few selected foods which have been shown to cause low degrees of sensitization. To these, a few foods at a time are added. If symptoms are exaggerated, elimination and repeated addition of the suspected foods will cause remissions or exacerbations.

The most useful method is the use of an elimination diet in which the more common allergenic foods are eliminated. These are chocolate, citrus fruits, eggs, pork, sea food, tomatoes, nuts and milk. Some include wheat in this group. This diet allows sufficient variation and nutrient foods for any ambulatory patient on an out-patient basis.

A frequently raised objection to the theory of food allergy has been that most if not all allergens are proteins. Yet almost every physician has interviewed patients who complain of "strawberry rash" or "hives when I drink orange juice" or "I can't eat pork," or "chocolate breaks me out." One of the more vehement objectors to food allergies (6) has stated that "The common allergens are protean rather than protein."

Because vesicular eczematous eruptions of the hands occur with a fair degree of frequency, it has been suggested that rather than ingested substances being the cause, contact with the offending food may be the precipitating factor. In two studies (4, 5) this was carefully avoided, and the eruption still recurred when the food was given, and subsided when the food was eliminated.

One argument against food allergy was that if food allergens cause eczematous eruptions of the hands, they must be considered as possible etiologic agents in other eczematous eruptions, no matter what their localization. In one series (4), designed to study eczema of the hands, skin eruptions were found to be coexisting on feet, eyelids, legs, arms, face, scrotum, neck, groin, perianal region and axillae.

Ideally, elimination of proven allergens should afford permanent relief of symptoms. Practically, this is not true. An explanation which I, among others, offer is that the allergic pattern may change, the patient not remaining sensitive to the same food or foods, but the tendency toward allergy remaining.

There is not sufficient time even to open a discussion of psychosomatic factors which play a role in skin reactions, but I would like to mention that it is my firm conviction that, not only do psychosomatic factors play a great role in skin reactivity but that the combined effect of emotional lability and food allergy cannot be ignored. It is my experience that emotional tension or shock lowers the threshold of reactivity to certain foods. While control of emotions per se does not, in most instances, control the objective symptoms, it does lessen the itching tendency, which, with the elimination diet, will eventually cause control of the allergic response of the skin.

Dr. George V. Mann: It must be obvious to you that you are getting more and more rope with which to express your questions a little later. Now let us have Dr. Andrus change the subject a little again, and review the general nature of a very large and very pertinent problem, that of the management of cardiac failure and edema, with particular emphasis on sodium metabolism and the role of diet in these problems.

BIBLIOGRAPHY

1. Figley, K. D. and Rawling, F. A., Clinical Experience in Corn Sensitivity. J. Allergy **21:** 510, 1950.
2. Winkenwerder, W. C., Symposium on Food Allergy: The Internist's Viewpoint. J. Allergy **21:** 487, 1950.
3. Winston, B. H. and Sutton, R. L. J., Dermatitis of the Hands Due to Ingested Allergens, Arch. Dermat. & Syph. **58:** 335, 1948.
4. Livingood, C. S. and Pillsbury, D. M., Specific Sensitivity to Foods as a Factor in Various Types of Eczematous Dermatitis. Arch. Dermat. & Syph. **60:** 1090, 1949.
5. Flood, J. M. and Perry, D. J., Recurrent Vesicular Eruptions of the Hands Due to Food Allergy. J. Invest. Dermat. **7:** 309, 1946.
6. Sulzberger, M. B., Allergy: A Dermatologists Reminiscence and Speculations. J. Allergy **21:** 85, 1950.

CARDIAC DIETS

E. COWLES ANDRUS, M.D.

Diet in cardiac edema is only an adjuvant to the other and often effective means of handling cardiac dropsy. The real problem of cardiac edema is the expansion of the extracellular fluid compartment, or the interstitial fluid.

To get back to the subject where Dr. Eastman and Dr. Howard left it, the reduction of obesity to ideal weight or slightly lower is completely necessary in patients with congestive heart failure. If you can get his weight down you have conferred that much reduction in his load. This is the result of certain equilibrium. There is intake through the mouth and stomach, output insensible of fluid through the lungs and output also through the kidneys.

The intake of fluid is regulated by thirst and thirst insofar as it is understood reflects actually the state of hydration of the body cells. But for practical purposes, it is regulated as are certain other important factors, by the effective osmotic pressure of this interstitial or extracelluar fluid compartment. And the instrument by which the distribution of fluid in these compartments is principally regulated, is the body sodium.

Traditionally for a great many years it had been the habit of the profession to restrict fluids in patients with cardiac dropsy, and I think we are all regretful of the amount of discomfort which we have thus unwittingly caused patients with cardiac edema. Think of the thirst and distress which we evidently needlessly provoked. If sodium is properly controlled, the fluid intake of these patients can be vastly liberalized if not indeed allowed ad libitum.

The definitive basis on which our current conceptions of the role of salt in cardiac edema, are founded derives from some work which was done by Dr. Palmer Futcher and Dr. Schroeder when they were at the Rockefeller Institute together.

In a patient who is otherwise normal the injection of 24 grams of salt is followed by a sharp rise in the urine chloride and the weight gain is minimum. The serum chloride rises also. A dose of mercupurin given at the end of the procedure is only moderately effective.

However, take a patient with congestive heart failure, who has been treated and brought out of his failure and then is given 24 grams of sodium chloride.

In sharp contrast to the rapid and prompt elimination of the sodium chloride administered on the part of the patient with nothing more than bronchial asthma, there may be no sign of disposal of this, until later a rather large dose of salyrgan is given and even then a loss of urine chloride may not be as much as had been ingested.

We need not, I think, go into the still somewhat disputed area as to whether this retention of salt by the patient with congestive heart failure is the result of excessive absorption by the tubules from a normal urine flow or a reduced glomerular filtration presenting a smaller amount for absorption to the tubules. It is sufficient to say that in cardiac dropsy the regulating mechanism for the distribution of water and the size of the extracellular fluid compartment have somehow gone off the beam. Methods of treating this by the reduction of salt are by no means the perfect therapy, but, are so far among the best we can offer.

There are three general fashions in which this can be done. There is a diet of tradition, so-called Karell diet which was originally sharply defined, 800 cc. of milk. This would contain not more than a gram of sodium chloride. It can be augmented by fluid, but it should not be augmented, if one is to stick strictly to that regime, by other caloric material. It has an advantage that it is easy to give. It does not provide an adequate fluid intake and it by no means provides an adequate caloric intake, hence it cannot be kept up indefinitely, but it will sometimes tide a patient over a difficult point.

Beyond this it has become our habit to speak of gram and four gram salt diets. Roughly speaking if the individual's food is prepared without salt of any kind in cooking, and he avoids the obviously salt things, shellfish and canned vegetables and soups and meats that are prepared with salt, he will come out somewhere around two grams a day. Now, if the food is cooked with an ordinary amount of salt,—and that may vary from family to family—and no salt is added at the table, the patient will get four grams of salt or more a day. That is a considerable restriction when one considers that most of us have fallen into the habit of consuming from ten to twelve or more grams of salt daily. If such a restriction of salt is imposed or practiced, and if the patient faithfully lives up to it, the ability of the physician by means of digitalis, and the adequate use of diuretics if they are necessary, to control the reaccumulation of edema is considerably enhanced.

There is considerable current interest in substances which are intended to foil the absorption of sodium, namely, the cationic resins. These have a chemical avidity for sodium or potassium. They are usually ingested partially saturated with potassium and it is intended that the patient's diet may be made more palatable and less restricted by their administration.

In some instances they work dramatically well. Sodium is retained by the resin but chloride is disproportionately absorbed, and a mild degree of acidosis regularly results but this is not intolerable in the favorable cases. On the other hand some of the cases which appeared to do best at first, namely those in which early in the phase of ingestion of resin there is a profound, pronounced diuresis, tend to go into renal insufficiency. These individuals cannot tolerate the administration of resins.

Resins have certain other disadvantages. The regulations of the bowel habits of the patient often becomes much more difficult, although it can be accomplished even when large quantities of resins are ingested. Finally they are expensive. There is no immediate prospect that the price will diminish.

One final word of caution: In this climate, in the summer time, when the insensible loss of water and salt is excessive, one has to be more liberal with the regime of salt in the diet and much more inhibited with the use of diuretics.

HYPERTENSION

GEORGE V. MANN, M.D.

We are now ready to commence with the real business of the evening, namely, the question and answer period. Before we start that, however, I'd like to indicate that the season is open for me, also in the question period.

I don't have a wide clinical experience, but because I suspect there may be general interest in the problem—and I think I overheard Dr. Howard say that Dr. Gofman was in town a month ago—I would like to describe briefly some of the work we have been doing in regard to lipid metabolism in arteriosclerosis and heart disease, especially atherosclerosis. I think that should be a part of this discussion tonight.

You may have heard that there is currently under way, a large-scale study of the problem of atherosclerosis and the relationship of serum lipids to it. This problem was instigated about two years ago, shortly after Dr. Gofman first published his hypothesis in Science, relating certain substances in sera called lipoproteins to the presence and perhaps to the origin of atherosclerosis. The questions which he posed are several, but the fundamental ones are first, whether this material, this lipoprotein, is really of any greater importance, of any more significance in the diagnosis of atherosclerosis than is simply a measure of cholesterol or any of the other several indirect methods that we have.

As you may know, Gofman proposed that

measurement of serum lipoprotein was a considerably better means for this purpose than a cholesterol measurement. He further implied that in some way these substances are related to the genesis of atherosclerosis in humans. The answer to this question is difficult. We don't have the answer yet, but I would like to tell you briefly how we are trying to get it.

Four laboratories—Gofman's is one, ours is another, another at Cleveland under the direction of Dr. Page, and one at the University of Pittsburgh under Dr. Max Lauffer—are working jointly. We are doing a survey-type of study on a large number of individuals, probably about twenty thousand subjects will be measured. We are something over half way to that goal. We do a serum cholesterol measurement; we take a very brief clinical history which is designed to allow us to classify at least roughly into normal or otherwise and we do lipoprotein measurements by the ultracentrifuge technique.

We have found to our dismay that the accurate quantitation of lipoproteins is extremely difficult, more difficult I think than even Gofman thought when we started. You see, if we are to pool our data, it is essential that a sample of sera analyzed in each of the four laboratories would give the same result.

We found also that cholesterol measurements as conventionally done in hospital laboratories, including our own, were very unreliable. We further found that there was no available method for measuring cholesterol which would give adequate results, and this includes implicitly the widely used Schoenheimer-Sperry method.

A good deal of our time and energy then has been devoted to this problem of reliable measurements. This is a very important point because I suppose later on the question will come up, what is the normal cholesterol level in serum, and the answer is dependent upon the reliability of the methods you use. The four of us have done something over ten thousand measurements. We are particularly interested in those normal individuals who, after we have done an initial measurement change their clinical status—that is have myocardial infarctions. We hope to be able to find one hundred such subjects. Then, having that group we can look back at our laboratory measurements, and we think be able to say which of these two measurements best predicted the event. We have no final answer to that problem.

In relation to the discussion of obesity here we have been doing some research on patients at the Peter Bent Brigham Hospital in an effort to find whether the treatment of obesity will have some influence on the serum lipid levels, and by serum lipids I mean cholesterol and lipoproteins.

The assumption is made here, that the serum lipids do have something to do with the origin of atherosclerosis. I am not sure that is true, but it may be true, and it probably is. We studied a group of thirty-nine people whom we were able to induce to lose an average of nineteen pounds.

Some of these people were overweight and some of them weren't. Some of them were initially at their ideal weight by life insurance statistical standards. We found that if the lipoprotein level in the sera—the S_f 12–20 class—was fifty milligrams per cent or more to start with; that we obtained a reduction when the patients lost weight, but if it were below that—and incidentally at least half of all the people in this room and all the population will be below that—then weight loss had no effect. Similarly for cholesterol. The break there was at about 300 mgs per cent.

Another way of saying this is, if the lipid level is initially high, cholesterol above three hundred, lipoprotein S_f 12–20 above fifty mg. %, then a weight reduction will lead to a reduction of the serum lipid levels. We imply, although we cannot of course prove that this is likely to reduce the rate of development of atherosclerosis.

I mention this work because I should like this topic also to be open for the question and answer period.

QUESTIONS AND ANSWERS

Q. Does obesity, per se, influence the glucose tolerance test?

Dr. Howard: I can only answer that indirectly to say that I have never had the opportunity to do a glucose tolerance test on somebody whose weight is normal and then do it again on that patient a year later when she has gained fifty pounds. Going the other way, I think that if you take the average patient, you will find that a fair percentage of people who are overweight by considerable degree at least, have an abnormal glucose tolerance curve. But it depends much more on what that patient has eaten or not eaten the day before because that influences glucose tolerance curve enormously. If you take off a certain amount of weight from a fat individual, a fair percentage of those people will without any doubt have a lower tolerance curve when they are at a normal weight than they did when they were obese, provided they have been for a few days on a normal diet, not the reducing diet. But if you have somebody who is frankly diabetic, I have never seen anybody under those circumstances who has become non-diabetic by losing weight. The severity of their diabetes may improve and they may not have to take insulin when they have lost weight, whereas, they did require insulin before. But when you put them under stress, I have never seen one that didn't still have diabetes. I don't know whether that answers the question or not.

Dr. Mann: It is interesting that the obese mice, the genetically obese mice which Dr. Howard mentioned earlier, apparently have diabetes as a complication of their obesity. Here is a question which I should like to answer or rather consider because perhaps I should have mentioned it a little earlier in the discussion:

Q. Nothing has been said about the quality of foods as deficiencies of vitamins and minerals and possible unknowns and the quality of soils in which foods are grown?

Dr. Mann: We have said little here about what one might call the frank deficiency states, pellagra, scurvy and those things, and we will not have much to say about them principally because they are not a real and present problem in this country.

It has been but a few years since in the South at the Cincinnati General Hospital, for example, pellagra was a very common disease. Pellagra now in the South with a few possible exceptions in Mississippi, is a rare disease. In Boston at least, we have to depend upon City Hospital and chronic alcoholics for our teaching material illustrating the frank deficiency states with the exception of pediatric deficiencies.

Here is a question for Dr. Robinson.

Q. Of what value is diet in the control of acne?

Dr. Robinson: In the first place acne doesn't have a single etiology. We know that in most instances acne appears about puberty, and usually the lesions begin to regress at about 21 to 25 years of age. We know that antibiotics seem to control it to some extent but we are completely ignorant of the actual cause of the disease. Many young patients come in with the complaint that chocolate causes new bumps; pork products and other foods, chiefly fatty foods, such as ice cream, are also offenders. In my practice, I have eliminated fats, and I think on a logical basis, because the sebaceous gland is the gland where the primary pathology of the condition lies. It is my experience that a low-fat diet and a diet low in certain other foods, such as soft drinks will cause acne to improve without any other form of therapy. Certainly we can't use X-ray in youngsters; I think every dermatologist will agree on that, and we are left with the treatment of acne by local means, and empiric means at best, and I think that diet should be added to that field.

For Dr. E. Cowles Andrus—Would you please discuss the low fat, low cholesterol diet with reference to (a) its use clinically, (b) what clinical studies are necessary for intelligent application of this diet in suspected cases of coronary sclerosis?

Dr. Mann: That's a very big order, Dr. Andrus. Would you like to take some section of it, any section of it?

Dr. Andrus: No, I'm not as competent to answer that as you are. I'd like to hear what you have to say about it.

Dr. Mann: I don't know the final answers to that and furthermore I doubt if anyone knows. There are several points that I feel rather strongly about. First of all, I think there is no evidence to support and there are several reasons to criticize anything approaching a mass application of the elimination of fat from the diet.

In the first place, there is good experimental evidence that we need not consider cholesterol and other lipids separately. Cholesterol at best is a poorly absorbed substance. It is particularly poorly absorbed when other lipids in the diet are minimal. It is unique among sterols in that it is absorbed at all; there are very few others that are. Vitamin "D" is a notable exception but this only in trace amounts.

I don't believe any of you or any physician should recommend to *groups* of people indiscriminately that they should restrict the fat in their diet. I do think there is a group of people largely undetected in this country who, while I cannot presently give proof, I believe would benefit by a restriction of the total lipid in their diet, and they are people with hypercholesterolemia. We imply a normal level of cholesterol in the serum. The latter is a very difficult thing to define, partly because of the complications of methodology. If you have a decent reproduceable method it is reasonable to assume that a value of 300 milligrams per cent or more in the serum, excluding a few exceptional situations such as the last trimester of pregnancy perhaps, or biliary obstruction, a level of 300 mg. % or more of cholesterol is an abnormality. Furthermore, the clinical evidence suggests that people with these levels do develop atherosclerosis at an accelerated rate.

Furthermore, as I implied a while ago, these people with elevated cholesterol levels are also the people who will respond most readily to treatment designed to lower these levels. So far as I know, then, these are the only people to whom we can honestly and intelligently advocate a restriction of lipid intake, and in these people as the data of Keys, and ourselves and other people have indicated, it is not so much a restriction of cholesterol in the diet as it is the total lipids and calories which cause effective serum changes. If patients are overweight, they should certainly be reduced. Our experience indicates that it makes little difference whether they are overweight or not. If they would lower their body weight it will contribute to a lowering of their serum cholesterol and lipoprotein levels.

I am studiously avoiding any statements about the clinical implications of changing or trying to change the serum lipoproteins and cholesterol in human subjects.

If we have defined who should have his serum cholesterol lowered, at least in whom we should make the attempt, we are left with a dirth of methods to do it. I can give you nothing better at the present time than, in addition to weight loss, a suggestion that you try a low-fat diet. By low-fat I mean something less than fifty grams a day. Here, again, however, you will find considerable variation in the response. There are some people who habitually eat 100 to 150 grams of fat in a day, who will respond quite quickly when they are dropped down to 75, but by and large, it will take a reduction to fifty grams or less to accomplish a reduction of serum lipids.

There is a little evidence which only serves to confuse the picture that if you put subjects on an extremely low fat diet, analogous to that which they would receive on, say the Kempner rice diet regimen or some variation, then quite the opposite may result, i.e., the serum cholesterol level will rise. Gofman has observed this. We have seen it occasionally. I think Dr. Watkins who is here might like to comment on it since, I believe, it was seen in the Goldwater experience.

You ask what chemical studies are necessary for an intelligent application. I think we have implied many of them; it is quite a task. At the present time adequate serum cholesterol measurement is essential. There are a good many people presently involved in the problem, trying to set up the perimeters and the definitions as to how you should proceed clinically in this situation. You see, I haven't really, and I don't think anyone can answer the most prevalent problem, namely, what do we do with a man age fifty, serum cholesterol 240 mg. %, who has either angina pectoris, or a proven myocardial infarction and is fifteen pounds overweight. What should we do with him? I don't know. I don't think I would persecute him with a low-fat diet. If it were myself, I would lose thirty pounds with the low calorie diet I could best tolerate.

I am impressed with the undocumented but still suggestive evidence that in parts of the world where people are chronically starved, chronically undernourished in relation to calories, there seems to be less atherosclerosis. In this respect it is interesting that we have been collecting the sera from Guatemalan Indians who live back in the mountains, still tribalized, who are largely vegetarians. We have measured about 125 of these. They have very low serum cholesterol levels, equivalent to those we find in children in this country—125, 150 and rarely over 160 mg. %. Now I don't know the reasons for this, and I don't even know whether these people do have atherosclerosis. We are trying to find that out.

Dr. Andrus: May I make a comment, Dr. Mann? The serum level of cholesterol of three hundred, unless the method is very carefully controlled, may include a larger segment of the population than perhaps you intend to apply this to. Could you give us an idea what proportion of the individuals in the cooperative study had a serum cholesterol of 300 or over.

Dr. Mann: Since I am not privileged to speak for the Cooperative Group data I will only refer to data gathered in our own laboratory. I'm sorry I don't have here before me the table of normal values derived from about 500 observations on males between the ages of thirty and seventy, but as I recall, we found that less than sixteen per cent of those males of all that age span have a value of 300 milligrams per cent or more. These are randomly selected people insofar as we can acquire them. That is, it is not a hospital population we are sampling. They are largely industrially employed people. This says that sixteen out of 100 people would fall into the category of subjects who, I am contending should have some studied efforts made to lower the serum cholesterol.

Taking the entire population, it gets to be a considerable number. Adlersberg, studying largely a Jewish population in New York has estimated that perhaps as many as five per cent of the male population is hypercholesterolemic. All our evidence would suggest that 300 milligrams per cent is a reasonable place to make the cut, and something like 60 milligrams S_f 12–20 lipoprotein, but I shouldn't give much weight to that at the present time.

Q. Baltimore is the only major city in the country which does not permit the sale of skimmed milk. The reason given by the Health Department is that mothers would use the product to feed babies. Is there any evidence that butterfat is necessary or desirable for infant feeding, and would the panel discuss the ban on skimmed milk?

Dr. Mann: First, I'd like to hear Dr. Eastman's comments on the question of baby feeding.

Dr. Eastman: Not being a pediatrician I cannot answer the question about feeding of babies, but the question does come up not infrequently in regard to dietary management of pregnant women in whom you want to maintain adequate calcium and phosphorus intake and yet reduce calories; and for long years skimmed milk has been utilized for that purpose. All that is necessary is to write a prescription for "skimmed milk—one quart a day" and she receives it from the dairy.

Dr. Mann: There is a question here directed to Dr. Howard.

Q. What effect does the high-protein high-fat diet for the treatment of obesity have upon the cholesterol content of the blood?

Dr. Howard: Reference is presumably made to the Pennington diet with which we have had no experience. However many reducing regimens are really high protein, low fat diets, for the reduced calorie intake requires expenditure of energy from the body stores and this is furnished either as protein or fat. Thus the metabolic mixture actually burned by a person on an undernutrition regimen is high in protein and fat.

I have no figures as to what happens to the level of serum cholesterol in our patients who have lost a lot of weight by dieting. Some, however, who started with high cholesterol levels, did show fall of cholesterol concentration coincident with weight loss.

Dr. Mann: We have tried to answer this question in some work done with Dr. Olson of Michigan State College, but we really have never gotten the answer. We have considered this problem from a little different point of view than that stated by Dr. Howard. Because our hypothesis is that in the human dietary cholesterol and neutral fat should not be distinguished since cholesterol absorption is dependent on diet fat. The crux of the relationship is in the intestinal tract, and while it is true that when you reduce a man on a low fat, low calorie diet you are forcing him to metabolize a high protein, high fat metabolic mixture, the fact is that in that individual you are also minimizing reabsorption of cholesterol.

We know, for example, that a considerable amount of the cholesterol absorbed arises from the biliary secretions, so that I'm not sure but that the question posed here may involve some fundamental physiology which is very pertinent to the entire problem. To my knowledge the answer isn't available.

Dr. Robinson wants to defend himself here. I think he is sensitive to the remark that a child developed a vitamin "A" deficiency while on an elimination diet. Is that right, Dr. Robinson?

Dr. Robinson: Yes. It is hard to conceive that a child 2½ months old would not have had a pediatrician, and secondly, it seems hard to conceive that all of the vitamin "A" in that child's diet would have had to depend on milk, because I think it is almost universal now to give supplementary vitamins to an infant. I think the dermatologist was at fault but I also think the pediatrician should share the blame.

Dr. Mann: Let us turn to the question of hypertension, because I'd like very much to hear what the experts have to say about the dietary management of hypertension. You are no doubt aware that for thirty years there has been quite a little struggle both as to the origin of the idea and the clinical effectiveness of dietary salt restriction in the course of hypertension. The whole issue was re-precipitated so-to-speak when Kempner published his "rice diet" proposal.

Q. I'd like to ask Dr. Andrus what the status of the rice diet per se is and whether there are some more benign alternatives to a diet of rice and fruit juice.

Dr. Andrus: This depends a little bit upon where you sit. It works very well in Durham, in a fair proportion of instances, and I accept that as a fact. I think one reason why it works at the hand of Kempner and in that environment is that you have to get religion to live on it. You have to develop a cult of individuals who are worshipping that particular method of living. It appeals to the obsessivensss and to the compulsiveness of some individuals, and it is that type of individual who frequently develops hypertension. When properly attended to, it undoubtedly may afford a useful therapeutic tool, though to be candid, I would despair of conducting a case of hypertension indefinitely on the rice-fruit diet myself. We have had a few patients in the cardiac clinic at Hopkins, whom we have had on the diet and who followed it and who got evident benefit. The Goldwater experiment to which Dr. Mann has referred, and in which Dr. Watkins took part, I believe, represented a carefully controlled biological examination of the effects of the rice and fruit regime. The diet has another disadvantage—believe it or not—in this country a rice-fruit diet is relatively expensive.

Whether it is the low protein or low salt or some other factor in the Kempner diet which produces the advantage when it does have an advantage, one cannot say but certainly you get similar effect in hypertension if you can persuade an individual to live on a diet which is as low in salt as the rice-fruit diet is. You have to get down pretty low, to half a gram or thereabouts, and it is a pestiferous diet to prepare and an uncomfortable diet to live on.

There is one phase of danger of both these regimens with which I am sure you are not unfamiliar and that is that if you are misled into applying a low salt regimen in the case of hypertension with kidney damage, which happens to be a salt-losing nephritis in disguise, you are in trouble very soon.

Dr. Mann: Do you think it is safe and reasonable to put a patient on such a restricted diet without laboratory control?

Dr. Andrus: I certainly do not.

Dr. Mann: By laboratory control I mean serum electrolyte measurements and not, say, urine chlorides.

Dr. Andrus: Certainly. I don't think you can prescribe such a diet empirically at all.

Dr. Mann: And I presume the same would apply to the use of ion-exchange substances?

Dr. Andrus: Certainly, I should have emphasized that.

Q. (For Dr. Eastman) Who among pregnant women should have vitamin supplements or should they all?

Dr. Eastman: In my opinion, some kind of a crusade should be started to teach doctors, medical students, nurses, pregnant women, drug salesmen, writers of advertising matter for drug houses and writers of commercials for radio and televison that pregnant women do not need vitamin pills, or calcium and phosphorus pills. It is my own feeling that a diet in which there is a liberal amount of meat, milk, fruit, and green vegetables is altogether adequate. On the other hand, current trends would seem to indicate that iron supplements are desirable. Only diets which are very rich in meat seem to meet the iron needs in pregnancy, and for some years now, we have been giving routine iron supplements to all our pregnant women; and as a consequence we have found that iron deficiency anemias are much less common than formerly.

Dr. Mann: You do recommend iron, and it brings to my mind a question which is plaguing some nutrition circles. Should the iron have also a little copper and a little molybdenum thrown in? The molybdenum question I'm especially interested in because I think that idea originated or at least received some substantiation in an obstetrical clinic in Chicago. What do you feel about that?

Dr. Eastman: I'm not competent to discuss the theory of the advantages of molybdenum and copper along with iron. However, the preparation which I have used for a good many years is the very preparation which you are mentioning and which goes under the trade name of Mol-iron. The "mol" refers to the molybdenum. I find that this preparation is perhaps more acceptable to patients and is a little freer from gastrointestinal irritation.

Dr. Mann: Dr. Howard would like to hear more of the question of what we might call occult obesity developing with age. We mentioned it a little earlier, the tendency for muscle tissue to be replaced with fat as one grows older and thereafter the tendency to be misled by what the scales say. And if one actually weighs at age fifty what he weighed at age twenty-five to feel that therefore one is not obese.

Just to fill in a little background, this problem came up for intense study during the last war when one of the armed services was interested in physical appraisal and the adaptation of fighting men to their tasks. Studies were undertaken to try to ascertain body composition. A most horrendous, but I understand a fairly effective, method was used. It involved weighing an individual in air and weighing him submerged in water. Some interesting facts developed.

For example, members of a professional football team were found to be almost unanimously obese by scales and insurance company statistic ratings. But it was shown that according to density measurements their excess weight was not fat but protoplasm. As fat replaces protein tissue, fat having a considerably lesser density, specific gravity measurements will reveal this. A good research problem is the development of an adequate and simpler technique for readily appraising body composition, perhaps by some dilution method. This is a point of considerable interest.

Dr. Howard, would you like to make some comments on that?

Dr. Howard: No, I really wanted to hear the question answered because when I was in Medical School, the Insurance tables still said as you grew in age, your weight could increase. That was a normal thing. The weight of a fellow at 21 would be one thing and at 50 quite another. Actually about twenty-five pounds was the difference. Now, you add to that the fact that as he grows older and doesn't exert himself as much, even though his weight doesn't change, he changes considerably in the relativity of fat to protoplasm. Do you take that into account in your nutritional thinking?

Dr. Mann: In the first place I hope it is clear to everyone that when we talk about ideal weight as derived from life insurance tables, those tables are derived from a performance assay—that is to say they are derived in a sense of a weight at which a group of people did best in terms of health and longevity. These have been supplemented a little recently with some additional information which I think is subject to some statistical criticism, which says that people who lost weight do better health and longevity wise thereafter.

In the sense of the specific question that Dr. Howard has put: do we take into account this tendency to dilute the body substance with fat with age. I think the answer is no, that our techniques are far too crude to include what is really at the present time practically speaking an immeasurable quantity. We have no feasible way at present. It is not possible obviously to weigh patients routinely in air and in water. Furthermore, the gravity measurement is dependent upon certain rather difficult assumptions as to contained gas, for example, ventilatory gas and gas in the intestinal tract. So that the answer I think is no, we cannot take it into consideration, but we are interested in the problem and expect one day to be forced to face it. We suspect that it may be part and parcel of this whole problem of obesity.

Q. Dr. Mann: Someone asks the question of Dr. Howard, What about methyl cellulose in appetite control? And Dr. Howard tells me in an aside that he doesn't know. He never heard of methyl cellulose.

Now I have heard of it because I have been listening to Gaylord Hauser occasionally. (Laughter) He has emphasized this methyl cellulose, a common synthetic and easily obtained material which has the chemical characteristic of taking up a large amount of water. It swells just preposterously in water so that if you eat a little of it, say a couple of good big tablets of it, when they get into your stomach they take on so much water that in twenty minutes you feel as though you had eaten a turkey dinner. That bloated feeling does apparently have some inhibitory effect on your appetite. It's a crutch which encourages all concerned to neglect the basic issues.

That is one way to take our appetites away. I think there was a report recently in the Journal of the American Medical Association, of a patient with an esophageal obstruction after taking one of these things.

I'd like to ask Dr. Robinson a point of information for myself. The question of cutaneous xanthoma. The issue has often been raised whether these xanthomatous lesions seen sometimes on the skin are not an easily observed manifestation of the same disease which occludes coronary arteries. I'd like to know from him first whether he believes there is some morphologic relationship between these two manifestations, and more important, to what extent the cutaneous manifestations vary either spontaneously or with diet therapy?

Dr. Robinson: The most common of the group is xanthelasma, and xanthelasma is found in a particular group of individuals; those who are overweight and those who have become overweight at a fairly early age. Whether or not that group of individuals might be more prone to arteriosclerosis, I can't answer definitely because while xanthelasma has been most frequently associated in text books with diabetes, I have not found that to be true. There are about eleven xanthomatoses among which would be xanthoma tuberosum multiplex. Whether or not it is associated with internal manifestations, has not been established.

Dr. Mann: Are there any questions? Any oral questions that you would like to fire up here? The hour grows late. I think you will not often have an opportunity for such expert opinion as you have here. If there are no questions, then I would like to thank the Medical Society for the opportunity they have given us, and turn the meeting back to its President.

Dr. McLanahan: The Medical Society would like to thank you, Dr. Mann, for coming and the participants, and the members for being here and giving us this program.

Good night, the meeting is adjourned.

CLINICAL PATHOLOGICAL CONFERENCE*

CHARLES W. WAINWRIGHT, M.D.[1] and MORGAN BERTHRONG, M.D.[2]

Clinical History #593,713 F. A. J. Married. White. Male. Age 43. Admitted: Dec. 24, 1951. Died: Dec. 27, 1951.

Complaint: Shortness of breath over a period of two weeks.

Family History: Unimportant.

Past History: Typhoid fever at age of 23 years; scarlet fever one year before admission, otherwise he had enjoyed good health. As a Civil Service worker had had frequent physical examinations including chest x-rays. So far as he knows, never had any elevation of the blood pressure. Always rather heavy, about 220 pounds, but during the year before the present illness had reduced his food intake and had brought his weight down to about 185 pounds.

Present Illness: In retrospect the patient thought that probably for five or ten years prior to the present illness, he had noticed increasing dyspnea after vigorous exercise. About four months prior to his admission he had become quite dyspneic on the slightest exertion and this lasted one or two hours. It passed off uneventfully and did not recur. Two weeks before admission he developed a cold and had some cough productive of small amounts of clear sputum, and with the cough he developed increasing dyspnea, so that he would become short of breath with as little exertion as walking the distance of one block on the level. He never had expectorated blood and had no pain in his chest. He could sleep lying down and was never dyspneic at rest. Three days before admission he awakened to find that rather suddenly he was much more short of breath as compared with the preceding day; in fact he was too short of breath to answer questions or talk, and he found it difficult to dress himself. For the first time he became conscious of palpitation associated with his dyspnea but denied the presence of any chest pain or substernal pain or oppression. He saw his physician who found his temperature to be 97°, noted the dyspnea and found his blood pressure to be 130/110. Patient was admitted to a local hospital. There was no cyanosis but the neck veins were distended. An x-ray of the chest was made which showed "infiltration extending out and up from the left hilum." He was given Penicillin. The next day he was somewhat cyanotic and the pulse was accelerated, the rate being 120. He was given nasal oxygen and put on digitalis, but without any improvement. He was brought to Baltimore and admitted on the surgical service of the Johns Hopkins Hospital, with the provisional diagnosis of a mediastinal mass. Six hours later he was transferred to the medical service. He had had no pain, no edema, no chills or fever, and the only difficulty of which he complained was the dyspnea.

---

* Presented at the Annual Meeting of the Medical and Chirurgical Faculty on April 30, 1952, by the Johns Hopkins University, School of Medicine (Transactions 1952).

[1] Associate Professor of Medicine, School of Medicine, The Johns Hopkins University.

[2] Assistant Professor of Pathology, School of Medicine, The Johns Hopkins University.

Physical Examination: Temp. 101°. Pulse 100. Resp. 20. Bl.P: 101/80 equal in the two arms.

The patient is described as a heavyset and large chested man, lying flat in bed, breathing rapidly. Sitting up produced no decrease in his respiratory rate; he would have to stop in the middle of a sentence to catch his breath. The face was ruddy. There was no glandular enlargement except for some small cervical nodes. The pupils reacted actively to light and during accommodation. The extraocular movements were normal. The fundi were described as normal. There was a slight nasal discharge but no obstruction. The pharynx was considered normal. The neck was supple. The trachea in the midline; no venous distension in the neck was noted. The chest was large with some increase in the antero-posterior diameter, but the lungs were clear to percussion and auscultation. The diaphragms moved well and there were no adventitous sounds heard. The left border of the heart extended to the midclavicular line. There were no shocks or thrills. The heart sounds are described as distant and of only fair quality. The second aortic sound was louder than the second pulmonic and along the left sternal border, in the fourth interspace, there was a split second sound, the second component of which suggested an early diastolic murmur to the examiner, but only in certain phases of respiration. This was not definite and no other murmurs were heard. The liver edge percussed to the costal margin. There was no abdominal tenderness or mass. The spleen was not felt. The genitalia showed nothing abnormal. A rectal examination was not made. There was no clubbing of the fingers. There was no cyanosis, and no edema of the extremities. There were good pulsations in the vessels of the feet and the reflexes were normal. There was no motor or sensory disturbance.

Course in Hospital: The patient was put at complete bed rest and given oxygen by catheter. The following day he seemed somewhat less short of breath, but he still would become dyspneic on talking. There was no orthopnea. The venous pressure was 130 mm of water and the circulation time, arm to tongue with dechalin 30 seconds. The blood pressure was lower, having fallen to 90/60. The following day the patient, rather suddenly, became much more short of breath and his blood pressure was 88/70. At that time the venous pressure was 150 mm of water and the circulation time had increased to 75 seconds. The lungs remained clear on physical examination but the gallop rhythm had become more pronounced. His cough tended to increase and he complained of some substernal irritation which was thought to be aggravated by coughing, and he also complained of lower abdominal pain, but nothing further could be found on physical examination. Later that day he vomited. This greatly increased his shortness of breath and caused a recurrence of his abdominal pain. The splitting of the second pulmonic sound seemed more pronounced. The pulse rate was 120; respiration was labored at a rate of 28. The lungs still remained clear. The abdomen was soft, there was no spasm or rigidity, but still some tenderness in the left lower quadrant but no rebound tenderness. Oxygen which had been administered by catheter then was changed to a tent. This made him much more comfortable. The possibility of a pneumonia was considered and antibiotic therapy was instituted with Aureomycin. He also was given digitalis. His condition grew progressively worse, the shortness of breath increased and he was increasingly cyanotic. The heart was still not enlarged but the sounds now were considered of mushy quality and further comment is made of the existence of the protodiastolic gallop. The liver was thought to be somewhat enlarged and the veins of the neck became distended. Still the lungs remained entirely clear on physical examination. There was no edema of the lower extremities but the note is made that the right calf was 1½ cm larger in circumference than the left, but there was no tenderness. His condition grew steadily worse; his blood pressure was unobtainable, and he became very excited. This increased his dyspnea and terminated only when he collapsed, and death following in about five minutes.

On admission the temperature was 99° by rectum; in four hours it had reached 101°, and it varied between 100° and 101° for the next forty-eight hours when it reached a maximum of 102°, falling rapidly before death.

Laboratory Data:

Dec. 24, 1951	Blood: Hemat. 49. SR 10. WBC 13,000. PMN 64%. Lymph. 30%. Mono. 6% Smear shows no abnormal cells and platelets are adequate
Dec. 24th	Urine: Sp. Gr: 1.015. Acid: Sugar 0. Alb: Trace Occasional white cells, no casts
Dec. 25th	STS; Negative
Dec. 25th	Blood culture: Negative
Dec. 26th	Blood chemistry: NPN 45 mgm%. Sugar 92 mgm%. T. Prot. 6.9 gm%. Alb. 4.2 gm%. Glob. 2.7 gm%
Dec. 27th	NPN 54 mgm%. Sugar 132 mgm%. CO_2 22.1 m/eq. Chlor. 101/m/eq. Potas. 5 m/eq.

Electrocardiograms:

Dec. 24th	Rate; 94, P-R interval: 0.19 sec. Rhythm: S-A. P waves normal. QRS complexes: Tiny, variable Q3. Maximum deflection in limb leads (5.5 mm in Lead 1). T waves: Inversion T3, V1 and 3. ST segments normal. QT interval 0.38. R-R 0.66 (prolonged). Interpretation: QRS amplitude at lower limits of normal. Q-T interval prolonged. Digitalis "effect."
Dec. 25th	Since the record of Dec. 24th, 1951 the Q3 has disappeared. QRS amplitude is still at the lower limits of normal. Q-T interval 0.44. R-R 0.76 (prolonged).
Dec. 27th	Rate: 94. P-R Interval: 0.16 sec. Rhythm: S-A. P waves normal. QRS complexes: Low voltage in limb leads. Delayed precordial transition. Vertical axis T waves: Sagging ST 3 and V1 with inverted T waves. T2 low, upright. Q-T interval 0.40. R-R 0.68 (slightly prolonged).

Interpretation: Low voltage in limb leads. Prolonged Q-T interval. Abnormal T waves.

X-ray Outside film[3]

X-rays: J. H. H.

Dec. 24th	Chest: There is an irregular infiltration in the left lung field near the hilum apparently localized in the apical segment of the lower lobe. The lung fields otherwise are clear. The heart and great vessels are within normal limits. The etiology is suspected to be of virus pneumonia although a neoplastic process cannot be excluded.
Dec. 25th	Chest: There has been some resolution of the infiltrative process in the left lung as compared with the previous films of the day before, although this still does not exclude a tumor, it gives more support to the impression of pneumonia.

Summary

Dr. Wainwright: We'll have the x-ray, please. This film of the chest shows the shadow coming out from the hilum on the left side, Fig. 1.

Now then, in summary, we have a forty-three year old white man, who, for several years, was becoming increasingly short of breath, and four months prior to admission experienced a short, rather acute attack of dyspnea which passed off uneventfully. Two weeks before admission he developed an upper respiratory infection which greatly aggravated his dyspnea but did not provoke cough, hemoptysis or pain. He was singularly free from orthopnea. The day before admission he was awakened by extreme dyspnea and was now aware of palpitation. His physician found him short of breath with distended neck veins but not cyanotic, with a high diastolic pressure and a small pulse pressure. The only cyanosis commented upon was on the next day and it evidently was not profound; and at this time the infiltration that you have seen in the x-ray was described.

Thus far he had no fever, but on admission to the hospital in Baltimore his temperature was found to be 101°, and his blood pressure had fallen to a much lower level. His dyspnea was extreme but there was no orthopnea and no cyanosis. The veins of the neck were not distended. Although the chest was large it was not emphysematous, and on physical examination was found to be entirely clear. The heart was not enlarged, the sounds distant and of poor quality, a gallop rhythm was heard, there were no murmurs, and the second pulmonic sound was not accentuated. The liver was not enlarged and there was no edema.

The patient's course in the hospital was a stormy one, he lived but three days after admission, and had fever with a slight leukocytosis all the while. He continued to be dyspneic but was not cyanotic. His venous pressure was only slightly elevated, but the circulation time was quite prolonged and materially increased while the blood pressure remained low. The lungs remained clear on physical examination even though the respiratory rate and the pulse rate increased, and his respiration became more labored. The gallop rhythm persisted and became more pronounced, and the heart sounds became of increasingly poor quality and are described as "mushy." He developed lower left quadrant pain which persisted, but nothing beyond some localized tenderness was found. As he rapidly became worse, congestive failure developed and he died.

The laboratory data accumulated showed little that was of aid in the diagnosis. The x-ray of the chest showed a shadow in the left lung field which you have seen. The electrocardiographic studies showed variations from normal and appeared to be more than the digitalis he had received could account for. There was a tendency to right axis deviation though this was by no means distinctive. The changes were not specific but would appear to indicate that his heart was laboring under great strain.

---

[3] Dec. 22nd Chest: A chest film taken this date at St. Mary's Hospital, Leonardtown, Md. (two days before films at this hospital were taken) also reveals an infiltration extending from the hilum into the upper lobe on the left. The film is light, making it difficult to see much difference between the two sides on this particular film. The findings are essentially those as reported here on Dec. 24th and Dec. 25th, 1951.

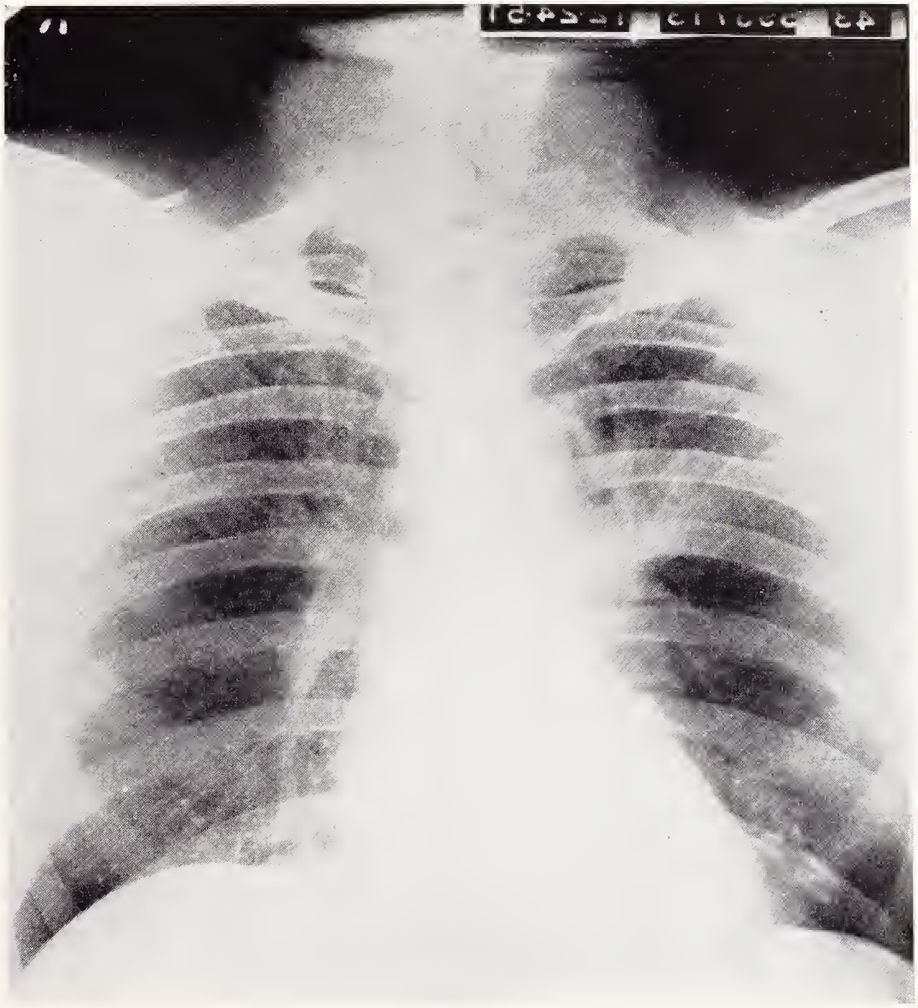


FIG. 1

DISCUSSION

DR. WAINWRIGHT: In the discussion of this case we must consider the problem in three ways. 1) Was there anything within the mediastinum but without the heart or lungs which caused this difficulty? 2) Was the cause of his trouble primarily pulmonary? 3) Was the condition which produced his symptoms and caused his death cardiac?

With regard to the first question the only condition which might be considered is a mediastinal tumor. The possibility of this is suggested in the appearance of the chest by x-ray, and to the roentgenologist the shadow coming out of the left hilum was capable of this interpretation. To suggest it, however, is to dismiss it, for the history is much too long; and to have experienced such a degree of dyspnea from a mediastinal tumor there surely would have been obstruction of the trachea with stridor and most surely other evidences of a space occupying mass.

The decision as to whether his condition was pulmonary or cardiac is more complicated, and one must consider both chronic and acute lung conditions in seeking a pulmonary origin for his symptoms and signs. Of the chronic pulmonary conditions, emphysema with its accompanying chronic basal infection and interstitial fibrosis of the lung would merit consideration.

Although the patient had had increasing dyspnea for four or five years, it was not the story of emphysema and chronic bronchitis, and exacerbations with each recurring respiratory infection. His chest is described as being one with increased anteroposterior diameter but it was not found emphysematous by x-ray. Cough and sputum were conspicuously absent, and whereas the lack of orthopnea would suggest that his dyspnea was pulmonary in origin, the results of increasing obstruction to the pulmonary circulation were not present. There was no accentuation of the second pulmonic sound, no chronic cor pulmonale, or a failing right heart. There was only dyspnea on exertion without cyanosis, with his capacity for activity steadily decreasing.

Interstitial fibrosis of the lung was described originally by Hamman and Rich as acute and was a diffuse thickening of the alveolar structure, producing obstruction to the pulmonary circulation. The course was often a matter of weeks or months, but was acute as such diffuse pulmonary disease goes. The pulmonary phase of the condition was dominated by dyspnea and cyanosis, but often the patient was not seen until heart failure had developed, and frequently the underlying pulmonary difficulty was not appreciated, being so completely over-shadowed by the heart failure. However, the heart failure was right sided with all of the cardiac manifestations of obstruction of the pulmonary circulation. In this instance what would have to be considered as the pulmonary phase of the disease was long, four or five years. Cyanosis was not present and right-sided heart failure appeared only as a terminal event. In either pulmonary fibrosis or in emphysema, obstruction to the pulmonary circulation is the mechanism by which the condition leads to a fatal determination. It was lacking in this case, and diffuse pulmonary disease would have produced a picture quite different from the case in hand.

As to any acute pulmonary condition, one would consider a pneumonia or pulmonary embolism. The onset of his terminal illness was not that of an ordinary pneumonia and the fact he had no fever for forty-eight hours after the onset would be most unusual in pneumonia. Furthermore there were no signs of consolidation on physical examination, the intoxication of the disease was not present, and cough, sputum and hemoptysis were likewise lacking. If the shadow shown by x-ray was an infiltration, it was central, which would account for the lack of physical signs, and would suggest an atypical or virus pneumonia. If such was the case here, one would surely have to consider some affection of the myocardium concurrently present, and that the pneumonia threw the balance in an unfavorable direction so far as his cardiac compensation was concerned. One might also consider the extension of a virus pneumonia to the myocardium, but such a viral myocarditis would not account for the antecedent history of increasing dyspnea over four or five years.

With regard to pulmonary embolism one cannot be too sure. The sudden onset of dyspnea without pain and the delayed febrile response are quite like pulmonary embolism. The signs of infarction were not present, but this is dependent upon the amount of pulmonary congestion and the shadow in the left hilum could well be pulmonary vessels brought into prominence by embolism. Also, there is the matter of the difference in size of the legs. It was not great and may have been of no significance whatever. A fatal pulmonary embolus is a large one, and the thrombosis of a leg vein responsible for a fatal embolus would be expected to produce more edema than was the case here. It is, however, the course of events which is unlike fatal pulmonary embolism. A large straddle embolus may cause death with such rapidity that the usual manifestations, dyspnea and cyanosis, do not have an opportunity to appear. Others go for longer periods when dyspnea, cyanosis and shock do manifest themselves and death is a more profound respiratory struggle, and the cardiac manifestations are those of acute cor pulmonale. Smaller emboli occlude only branches of the pulmonary artery and do not cause death, but such circulatory strain as they produce also falls upon the right heart. There was no evidence of right heart strain here unless the small right axis deviation could be considered as such. This was the only evidence that could be regarded as indicating any degree of obstruction to the pulmonary circulation. Furthermore once a pulmonary embolism has occurred and is survived, the patient improves, whereas this man steadily grew worse, but never with evidences of congestive failure until shortly before death which came after four days. Again a small and non-fatal pulmonary embolus might create sufficient embarrassment to an already damaged heart to tip the balance toward increasing failure.

As to the consideration of the third possibility; was this patient's fundamental difficulty with his heart; it does not appear that he had a long-standing hypertension as his heart was not enlarged, but this does not preclude the possibility of arteriosclerosis of the coronary arteries. In the absence of chronic pulmonary disease to account for his increasing dyspnea over four or five years, one must conclude that his myocardium was at fault. One is struck by the lack of orthopnea as his dyspnea increased, and even more by its absence after entering the hospital here, but right sided failure never was conspicuous until terminally, as indicated by the slight degree of increase in venous pressure. On the other hand the circulation time was high on admission, and quite definitely increased during the remaining days of his life. One would take this to mean that his heart was having difficulty in emptying itself but had not yet reached the point of backward failure, with congestion of the venous circulation, or that the circulation of the lung was impeded. What then could produce such a state of myocardial inefficiency over so long a period to culminate in death in heart failure? At his age one might still consider rheumatism, but in the absence of some evidence of valvular heart disease, much less cardiac enlargement, it would be remarkable to have extensive rheumatic myocarditis. One need not consider syphilis seriously for the Wasserman reaction was negative and there was nothing to suggest either luetic aortitis or aortic insufficiency. In the rare instance of luetic myocarditis, in the absence of aortitis and aortic insufficiency, the heart has been found much enlarged and failure rapidly progressive. The only types of myocardial disease which would explain the picture are a non-specific myocarditis—the so-called Fiedler's myocarditis, and arteriosclerotic heart disease, the latter the result of coronary arteriosclerosis and the diffuse minute scarring that may ensue.

Fiedler's myocarditis is an acute inflammation which runs its course with little or no fever, with evidences of stasis in both the greater and lesser circulations and because of its insidious nature its duration is by no means well defined. It would hardly seem reasonable that it would be so virulent as to run its course in five days, nor would it account for the increasing shortness of breath which the patient experienced over a period of four or five years. On the other hand it is not unusual in coronary arteriosclerosis without hypertension to see areas of myocardial degeneration, with fibrotic change as their sequel, which is gradual in its development and which produces a steadily lowering myocardial reserve. Under such circumstances the heart may or may not be enlarged and the slowness with which this change develops, allowing collateral circulation to come into play, is a major determining factor in the size of the heart. Such a course of events would best explain what happened in this case. This man had experienced steadily decreasing myocardial reserve as indicated by his increasing dyspnea, but he never developed frank congestive failure.

Four days before death something more acute happened, characterized by extreme dyspnea which seemed much more than mere paroxysmal nocturnal dyspnea and suggested rather a pulmonary embolus or a myocardial infarction. There was no pain associated with this occurrence, and whereas pain is a usual accompaniment of myocardial infarction, it may be absent. Likewise, there was no specific electrocardiographic change. These are not essential and one can be led astray when one refuses to make a diagnosis of myocardial infarction in the absence of specific electrocardiographic changes. The most disturbing feature in reaching such a conclusion is the size of his heart. With it definitely enlarged this would be important, and White goes so far as to say that a very large infarct is always attended by cardiac enlargement.

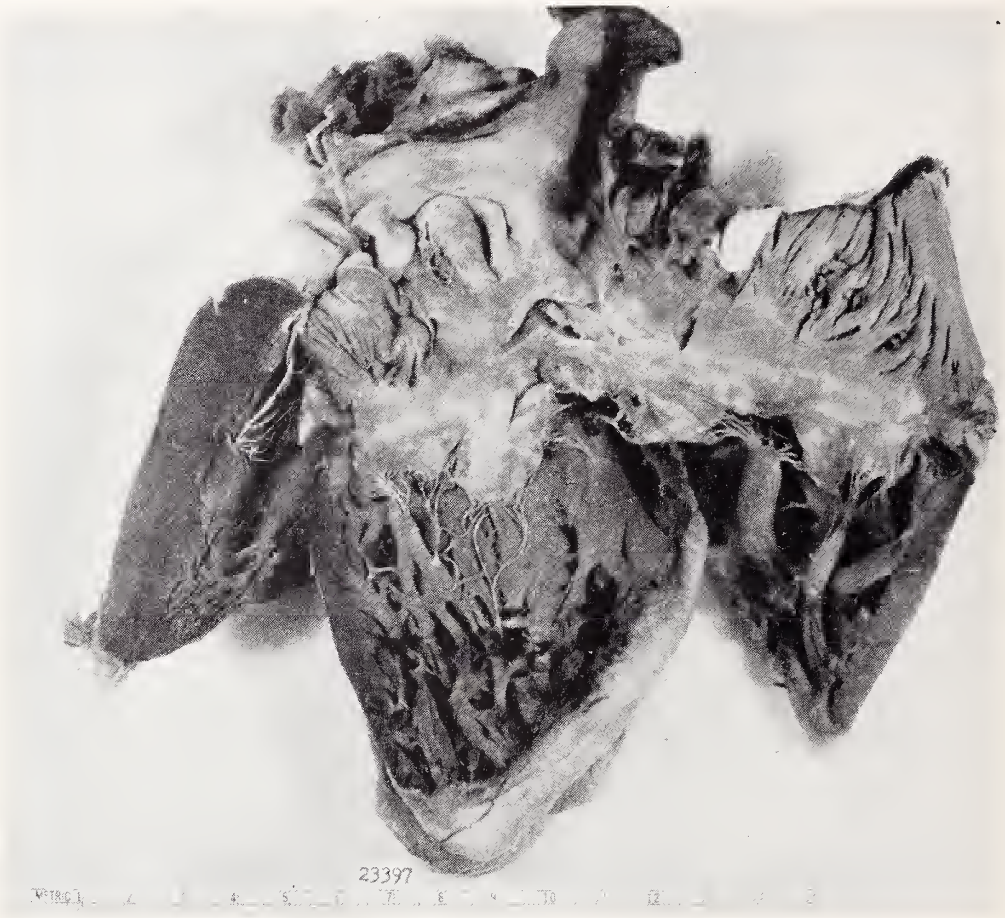


Fig. 2

In contrast, when the patient was admitted to the hospital the heart sounds were described as distant and they steadily deteriorated in quality until they were described as "mushy." A protodiastolic gallop was present which became increasingly more pronounced. Thirty-six hours after the event he developed fever which continued, and there was some leukocytosis but the time and nature of the febrile response would be in accordance with either a myocardial infarction or a pulmonary embolism. It seems to me that the weight of the evidence points to this patient's fundamental difficulty being myocardial rather than pulmonary and that he had coronary arteriosclerosis with diffuse fibrosis rather than a non-specific type of myocarditis, which occasioned a steadily decreasing myocardial reserve.

As a terminal event again, the weight of the evidence points to a pulmonary embolism as indicated by the sudden increase in dyspnea, the lack of pain, absence of specific electrocardiographic change but rather a tendency to right axis deviation, the delayed febrile response with some leukocytosis and the possible source for an embolus in a leg vein. Following this added insult, myocardial failure ensued, causing his death four days later. This would account for the pulmonary shadow in the left hilum as prominent pulmonary vessels rather than to consider it an unrelated pneumonia or at most tipping the balance toward failure. With such an interpretation it is not easy to explain the terminal lower abdominal pain unless it could be an embolism to an abdominal artery from a mural thrombus, for it takes but little failure for mural thrombi to form.

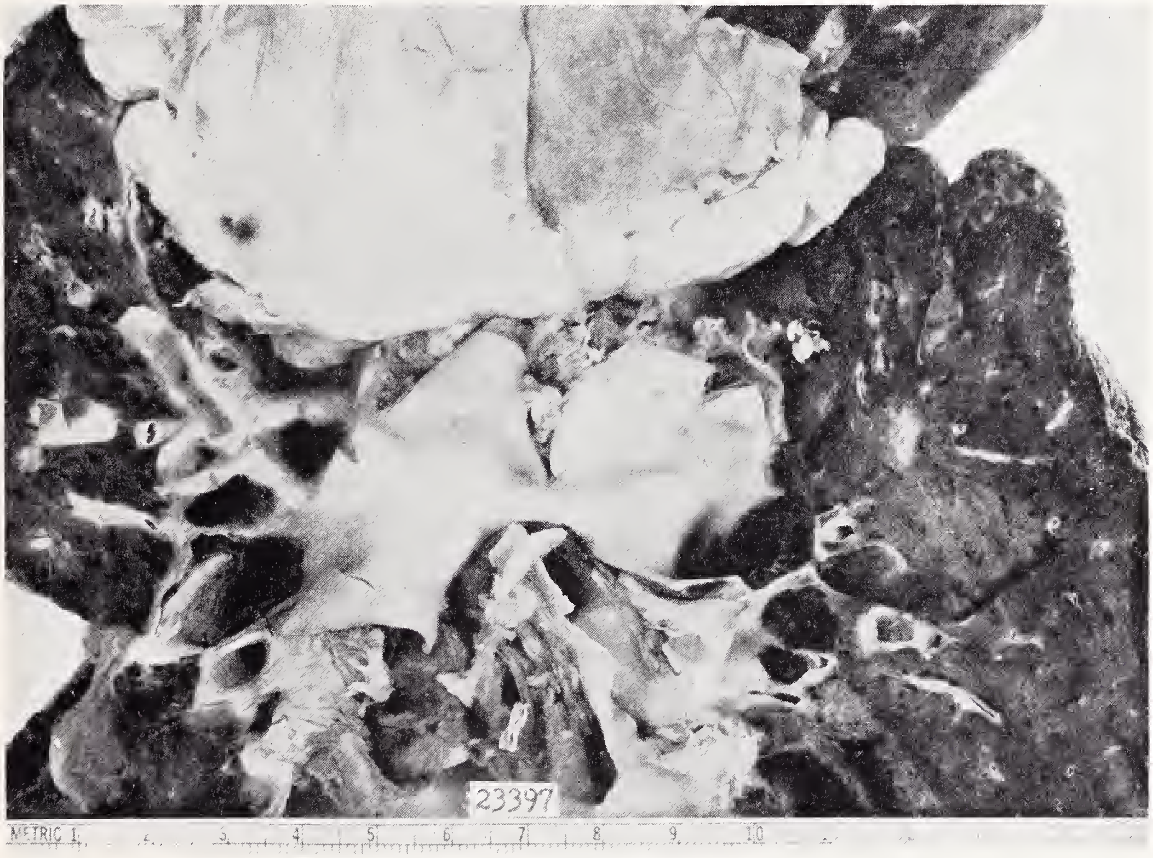


Fig. 3

One cannot be too sure that he did not have a myocardial infarct but the weight of the evidence seems to me against it. For me it is difficult however to make the decision because the underlying changes thought to be present in the heart would certainly be conducive to myocardial infarction, but there is important evidence which seems to me to be lacking.

Discussion

Dr. Berthrong. Mr. Chairman, Ladies and Gentlemen: In spite of my lack of seniority before this audience and Dr. Wainwright, I must still fulfill a role of the Pathologist which, at such a gathering, is to harass the clinician. I am sure this will be accepted without offense. Dr. Wainwright, of course I look at it in retrospect, but it seems to me as though a very prominent feature in this person's illness began as and continued to be dyspnea. This seemed to be completely out of proportion to the patient's chest signs and to his x-ray. In my recollection most patients who die with left ventricular strain such as would be produced by chronic coronary insufficiency should show more pulmonary signs, should show rales at the base, should not show the severe dyspnea seen in this patient which was not increased by lying flat in bed. I don't recall patients with left ventricular failure exhibiting such manifestations. Would you comment on that?

DR. WAINWRIGHT: Dr. Berthrong, that is quite true, it is very difficult to explain. I think sometimes that the amount of congestion in the lung is very variable; it may be minimal and scarcely detectable whereas in other times it is very prominent and I must confess I'd be far more happy and feel far more secure in my conclusions about this man had he definite evidences of pulmonary congestion.

DR. BERTHRONG: This is an extremely interesting case, not common but I think it is not as rare as has been noted in the past. Autopsy showed an extremely obese white man who at the time of post-mortem had intense cyanosis. This cyanosis was peculiarly noted in the face and the upper extremities and I do not have an explanation for that distribution. It was noted in Dr. Wainwright's discussion and he emphasized it in discussing the development of pulmonary emboli that one of the legs had an increased circumference. The measurement specifically showed that the right leg in the calf region and in the thighs was three to four centimeters larger than the left. I am not completely convinced that our post-mortem data show that small variations in leg circumference are significant but when it is as of great a difference as this patient exhibited, I am sure it may be of great importance. It was furthermore noted at post-mortem examination that when the prosector attempted to milk blood from the veins of the right leg, none could be obtained. Unfortunately we are not permitted to dissect the extremities so we do not know what was in the leg veins. The heart was enlarged and weighed 450 grams. This enlargement was essentially limited to the right ventricle (Fig. 2). In the major pulmonary arteries, adherent and fresh thrombi were seen (Fig. 3). Microscopic sections showed organization of many of the large thrombi, extensive enough to suspect that the thrombi had been present for many weeks, even months (Fig. 4). Other thrombi were quite fresh and obviously had occluded the small lumina remaining after the old thrombi had organized. These fresh thrombi, whether arising in situ or as emboli, were doubtlessly the cause of the terminal episode which Dr. Wainwright correctly diagnosed.

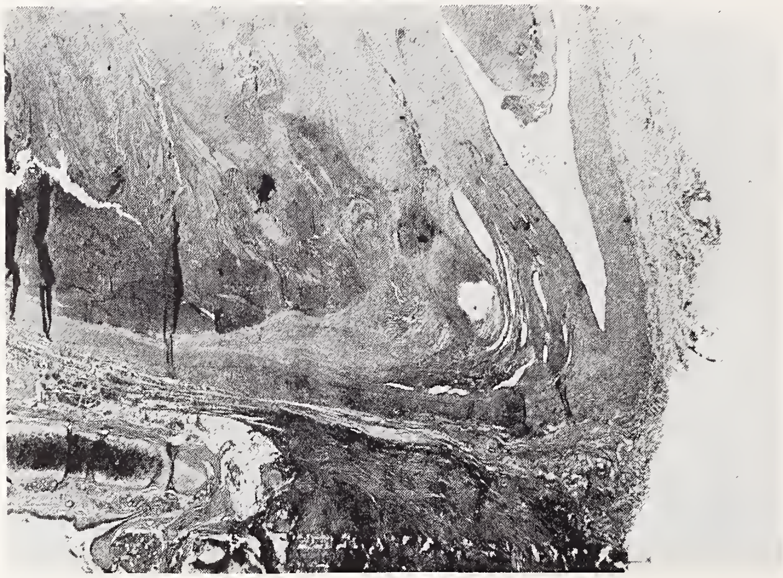


FIG. 4

Other sections showed smaller pulmonary arteries in the lung which contain partially organized thrombi (Fig. 5). The pulmonary parenchyma was normal except for the presence of considerable anthracosis and occasional small silicotic nodules. Very interestingly there were marked arteriosclerotic changes in the smaller pulmonary arteries (Fig. 6). I say "arteriosclerotic" because these were typical of the pulmonary arteriosclerosis that is seen in so-called Ayerza's disease. It should be pointed out that these plaques of intimal proliferation were also compatible with old thrombi which had been completely organized and recanalized to leave small crescentic-shape lumina in these terminal pulmonary arteries.

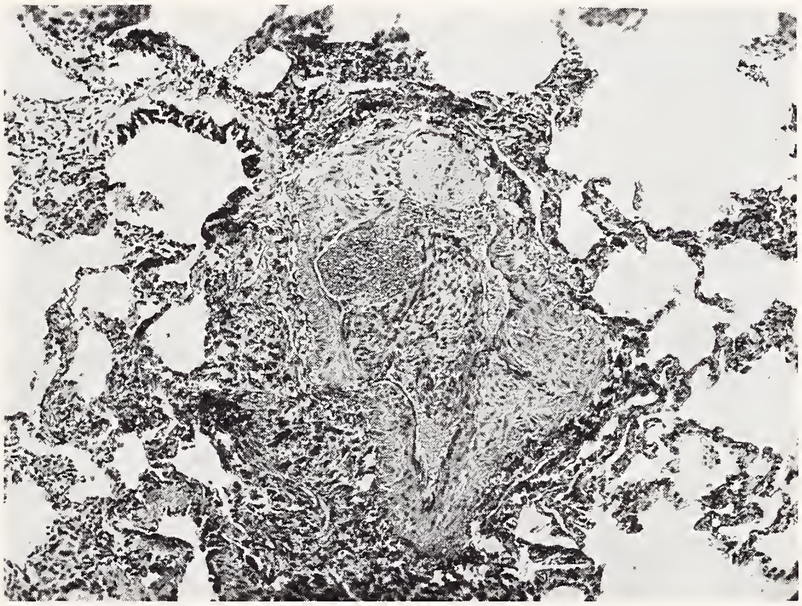


Fig. 5

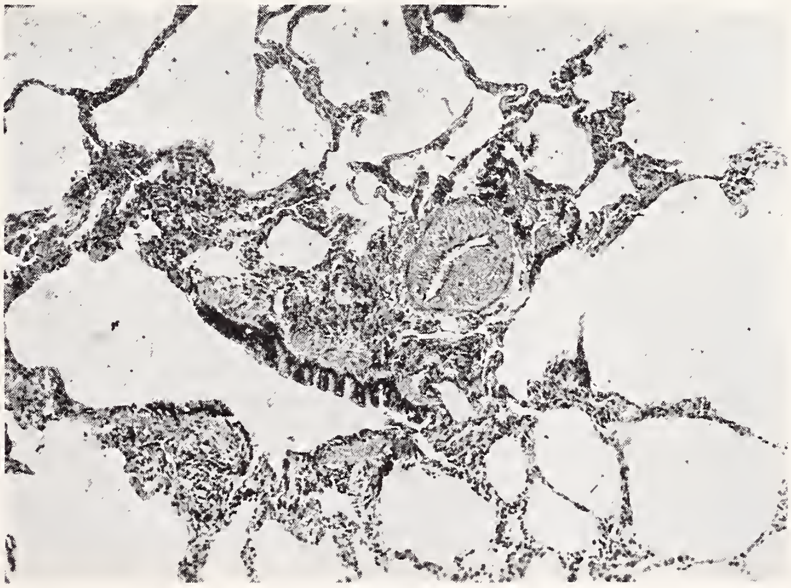


Fig. 6

We now can postulate that this patient for some unknown reason began to develop pulmonary embolization or thrombosis four or five months ago, which partially occluded his major pulmonary arteries. Smaller emboli occurred in smaller pulmonary vessels. Why he did not exhibit more of the clinical manifestations of chronic cor pulmonale is not entirely clear. The relationship of the mild but definite pulmonary silicosis to these pulmonary thrombi cannot be clearly stated. We have had possibly ten autopsies of cases of this syndrome in the past few years. It is becoming of increasing importance to recognize this peculiar clinical combination of severe dyspnea in the absence of prominent chest signs and often with cough and often with prominent hilar shadows by x-ray which I think must represent dilated major pulmonary vessels proximal to the thrombi or even the vessels enlarged by the thrombi. All of the patients have not manifested an absence of orthopnea but others have shown it as a prominent feature. Some of the patients are cyanotic, which is not always easily explained. In this patient I think it is perfectly clear that as the right atrial pressure rose, there was an anatomical patency of the foramen ovale allowing a shunt of blood across from right to left and providing an easy explanation for the cyanosis. All of the patients have not had a patent foramen ovale and the explanation of cyanosis is then not understood. The thrombus material has been found in the major pulmonary arteries in all of our cases which has led to incomplete occlusion or stenosis of the major arteries. Since death did not occur immediately, symptoms developed later when the pulmonary stenosis resulted in right ventricular strain and eventual failure. The origin of the emboli has occasionally been found in the leg veins but in others, as in this case, no source for emboli or etiology for thrombosis has been discovered. Since left ventricular failure has usually not been present in these cases, pulmonary infarcts have not been seen.

1. Carroll, D., Chronic Obstruction of Major Pulmonary Arteries, Am. J. Med., 1950: **9:** 175

ARMED FORCES DISCOUNT REPORTS ON HEPATITIS RATE

THE AMA WASHINGTON LETTER NO. 7, FEBRUARY 13, 1953

Following press reports of high incidence of homologous serum jaundice (hepatitis) among U. S. troops getting plasma, the Armed Forces Medical Policy Council and Army Surgeon General's office decided the record should be set straight. These points were made: (*a*) Studies show that 23% of the severely wounded receiving 5 to 10 units of plasma contract hepatitis from 60 to 180 days after the infusions, but mortality rate is only one in 1,000 cases, (*b*) while serum albumin has been found free of hepatitis virus, there isn't enough supply to replace plasma, (*c*) a National Research Council committee is working on sterilization of plasma but until it arrives at a solution, plasma will continue to be used by the services. Officials said they were anxious that the public not stop donating blood because of the misinformation on plasma.

Component Medical Societies

ALLEGANY-GARRETT COUNTY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

The Allegany County school health program is being expanded, due to the addition of Dr. Ralph Reiter, local physician, to the health staff on a half-time basis. Dr. Reiter will give physical examinations to students who need medical attention, but who have not had help because their parents were unable to afford it. On completing examinations if medical attention is needed, the child will be referred to a private physician, or one of the many special clinics offered by the Health Department. Dr. Reiter has been busy with immunization work in the schools during the past 3 months.

Dr. W. Royce Hodges, local obstetrician spoke before the Allegany County lay health group, February 17, in the Union St. Building.

The following is quoted from the Cumberland Sunday Times:

"Dr. Winthrop Phelps, Baltimore, a world famous leader in the treatment of cerebral palsy, checked the condition of more than 80 children who appeared at the clinic conducted by the League for Crippled Children, City Hall Square. Seven of the patients were from Garrett County. The League brings leading specialists for clinics here in the fields of infantile paralysis, spastic afflictions, cerebral palsy, orthopedic ailments, children's abnormalities and related handicaps. The next clinic will be conducted by Dr. David Weinberg, Baltimore, in March, for orthopedic cases."

"Dr. E. Don Taylor, 73, well-known physician at Lonaconing since 1921, died on February 10, 1953, at the Memorial Hospital.

"In May of this year Dr. Taylor would have completed 50 years as a practicing physician. He had been in ill health a number of years. He was a native of Downs, Kansas, and came from a family of physicians. His father and grandfather both were doctors. During his childhood he moved to Moline, Ill. In 1903 Dr. Taylor graduated from Hahnemann Medical College in Chicago. He was a practicing physician following graduation at East Moline, Ill., where he also served for a time as mayor. On March 15, 1910 he married Miss Katherine Swanson, of Moline, who survives. During World War I, Dr. Taylor served in the Medical Corps and in 1919 he came to Lonaconing during the influenza epidemic. In 1921 he returned to Illinois, later moved his family to Lonaconing and had maintained his office and residence since at 15 Douglas Avenue.

"Dr. Taylor was active in a number of organizations. He was a member of the Lions Club of Lonaconing; had been a director of the Lonaconing Savings Bank; Allegany-Garrett Medical Association; Georges Creek Valley Lodge 181, AF & AM; Scottish Rites Consistory; Ali Ghan Shrine Country Club, Royal Order of Jesters, and Lodge 470, BPO Elks, Frostburg. American Medical Association; Moline, Ill., Masonic Lodge; and James P. Love Post 92, American Legion, Lonaconing.

"Surviving besides his wife are a daughter, Mrs. Joseph Reese, at home and a brother, R. Mac Taylor, Berlin, Pa."

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

More members of the Society are coming to meetings. The upswing in attendance follows the pace of the scientific programs started last year. The Program Committee has raised the average audience from about fifty (generous) to the neighborhood of two hundred (conservative) in one short year. The February symposium on diabetes was no exception, the Hall was packed. Perhaps the questions were fewer than at some meetings, this was due more to the thoroughness of the coverage than any lack of interest.

The testimonial to GUS, given full coverage elsewhere in this Issue, was a surprise to most of us. It lifted the curtain for the nostalgic past for a few moments.

Coffee and doughnuts—courtesy the Auxiliary—after the Meetings is catching on. In January the

Ladies set up their stand in a side room and were inconspicuous, and perhaps not overly patronized. In February the table was in the main right-of-way and did a land office business. Eased the checkroom jam a lot, too.

The report of the Committee on Blue Shield payments to Hospitals has brought no further action. The thorough investigation of Dr. Ed Jarrett and his committee was fully discussed in the January Meeting. President Fort's summary of the Society's attitude seems to have hit the nail on the head: Trust has to start somewhere with somebody and, as long as the responsibility for these sums is kept with the *professional* staffs of the hospitals, the Medical Society can do no more. Responsibility lies then with the doctors to see that their hospitals do not practice medicine in competition with their own visiting staffs.

Revision of the Constitution of the City Society has progressed from the committee stage to legal review. It will be sent to each member for 'committee-of-the-whole' action. Each of us is expected to read and find mistakes. Any real errors should be corrected before passage, amendments later are to be avoided. Errors found, or desired changes, should be called to the attention of the Committee in advance of discussion on the floor, if possible.

The Course in Electrocardiography under the auspices of the City Society began on schedule Tuesday, February 24. Meetings are held in the Auditorium of the Nurses Home of the Union Memorial Hospital. The first two meetings have been very well attended. The decision of Dr. Whitehouse to make annual Staff instruction lectures open to the members of the Society seems to have been a very happy one.

BALTIMORE COUNTY MEDICAL ASSOCIATION INC.

DONALD L. SOMERVILLE, M.D.

Journal Representative

The Baltimore County Medical Association has now completed its proceedings for incorporation, thanks in large part to the efforts of its legal advisor, Mr. William Wells. It seems apt to publish the legal document *in toto* for the enlightenment and guidance of other Medical Societies which might wish to follow a similar course of action. The Baltimore County Association is satisfied that this is a wise thing for many reasons, previously discussed in these pages.

The following is a copy of the Act of Incorporation:

BALTIMORE COUNTY MEDICAL ASSOCIATION INC.

Articles of Incorporation

FIRST: WE, THE UNDERSIGNED, Charles H. Williams, M.D. whose post office address is No. 1632 Reisterstown Road, Pikesville 8, Maryland, Charles F. O'Donnell, M.D., whose post office address is No. 7501 York Road, Towson 4, Maryland, and Thomas E. Wheeler, M.D., whose post office address is corner Liberty and Clifmar Roads, Randallstown, Maryland, each being at least twenty-one years of age, do hereby associate ourselves as incorporators with the intention of forming a corporation under and by virtue of the General Laws of the State of Maryland.

SECOND: The name of the corporation (which is hereinafter called the Corporation) is BALTIMORE COUNTY MEDICAL ASSOCIATION INC.

THIRD: The purposes for which the Corporation is formed are as follows:

1. To bring into one organization the physicians of Baltimore County; so that by frequent meetings and full and frank interchange of views they may secure such intelligent unity and harmony in every phase of their labor as will elevate and make effective the opinions of the profession in all scientific, legislative, public health, material and social affairs, to the end that the profession may receive that respect and support within its own ranks, and from the community, to which its honorable history and great achievements entitle it; for fostering a fraternal feeling among its members and promoting their ethical relations, and to do the things that stand for the benefit of the civic body and the advancement of the medical profession.

2. To acquire, own and hold such real and personal property as may be necessary and convenient for the transaction of its business and in furtherance of its purposes, and to sell, lease, encumber, mortgage, transfer, rent, and otherwise deal with or dispose of real and personal property as may from time to time be or become necessary in the conduct of its business.

3. To apply for, obtain, register, purchase, lease or otherwise to acquire, and to hold, use own, operate and introduce, and to sell, assign or otherwise dispose of, any trade-marks, trade-names, copyrights, patents, inventions, improvements, and secret process used in connection with or secured under letters patent of the United States, or elsewhere, or otherwise, and to use, exercise, develop, grant licenses in respect of, or otherwise turn to account any such trade-marks, copyrights, patents, licenses, processes and the like, or any such property or rights, necessary and incidental to these purposes.

4. To acquire all necessary franchises, licenses, grants,

permits and other evidences of authority to carry on said business and to sell, transfer, assign or dispose of, in the manner allowed and provided by law, said franchises, licenses, grants, permits or other evidences of authority to carry on said business.

5. The Corporation shall have no capital stock and whatever profits shall accrue to the corporation shall be used for the promotion of the general good and welfare of its members and for the furtherance of its business.

6. The foregoing clauses shall be construed as both purposes and powers and the matters expressed in each clause shall, except as otherwise expressly provided, be in no wise limited by reference to or inference from the terms of any other clause, but shall be regarded as independent purposes and powers and the enumeration of specific purposes and powers shall not be construed to limit or restrict in any manner the meaning of general terms of the general powers of the corporation, nor shall the expression of one thing be deemed to exclude another, although it be of like nature, not expressed.

7. The above granted powers to the corporation are in furtherance and not in limitation of the general powers conferred by law upon corporations.

FOURTH: The post office address of the principal office of the Corporation in this State is No. 1211 Cathedral Street, Baltimore, Maryland. The name and post office address of the resident agent of the Corporation in this State are, William D. Wells, 605 Reisterstown Road, Pikesville 8, Maryland. Said resident agent is an individual actually residing in this State.

FIFTH: The number of directors of the Corporation shall be seven (7), which number may be increased or decreased pursuant to the by-laws of the Corporation, but shall never be less than three; and the names of the directors who shall act until the first annual meeting or until their successors are duly chosen and qualify are: Charles H. Williams, Charles F. O'Donnell, Thomas E. Wheeler, David H. Andrew, James G. Howell, Melvin E. Davis, and Wilmer K. Gallager.

SIXTH: The duration of the Corporation shall be perpetual.

IN WITNESS WHEREOF, we have signed these Articles of Incorporation on this day of , 1952.

Witness as to all

....

....
Charles H. Williams

....
Charles F. O'Donnell

....
Thomas E. Wheeler

STATE OF MARYLAND: BALTIMORE COUNTY, TO WIT:

I HEREBY CERTIFY that on this day of , 1952 before me, the subscriber, a notary public of the State of Maryland in and for the County of Baltimore personally appeared Charles H. Williams, Charles F. O'Donnell and Thomas E. Wheeler and severally acknowledged the aforegoing Articles of Incorporation to be their act.

WITNESS my hand and notarial seal, the day and year last above written.

....
Notary Public.

WASHINGTON COUNTY MEDICAL SOCIETY

O. D. SPRECHER, M.D.

Journal Representative

VICTOR D. MILLER, M.D.

The Washington County Medical Society is proud of its gold star member, Dr. Victor D. Miller, 131 W. Washington Street, Hagerstown, Maryland. Dr. Miller was born in Washington County on March 15, 1876. His secondary education was accomplished at the Mercersburg Academy and Princeton University. He was graduated from the medical school of the University of Pennsylvania in 1900, and is a member of the Phi Alpha Sigma medical fraternity. His internship was served from 1900 to 1901 in the Germantown Hospital, Philadelphia, Pennsylvania and Kings County Hospital, New York.

He began the practice in medicine in Hagerstown in 1901, and is still active. He has been a member of the medical staff of the Washington County Hospital since 1905, and served as President of that organization. He has been a member of the American Medical Association, Washington County Medical Society, Cumberland Valley Medical Association, and the Medical and Chirurgical Faculty of the State of Maryland since 1903.

Dr. Miller has always been an active participant in community affairs. Among these are the following: Member of the 1st board of directors of the Hagerstown Y.M.C.A., President of the Washington County Chapter of the American Red Cross, Public Health Association, Chamber of Commerce, Rotary Club, and Fountain Head Country Club. During both World Wars he served on the Medical Advisory Committee of the local draftboard.

It is indeed a pleasure to congratulate Dr. Miller on achieving 50 years of service in the Medical Society.

QUARTERLY MEETING

The first regular quarterly meeting of the Washington County Medical Society was held at the Alexander Hotel, Hagerstown, Md., Thursday evening, January 29th, at 6:00 P.M.

The principal speaker was Samuel P. Asper, Jr., M.D., Johns Hopkins Hospital, Baltimore, Maryland, whose subject was: The newer aspects of the Treatment of Thyroid Disease.

W. Ross Cameron, M.D., recently re-appointed Health Officer of Washington County, spoke briefly concerning his recent tour of duty with the Medical Advisory Committee of the U. S. Army serving with the Nationalist Chinese Forces on the island of Formosa, his pleasure on returning to his present occupation and location, and the mild sporadic epidemic of infectious hepatitis in nearby Frederick County.

DEFENSE DEPARTMENT PROPOSES REGROUPINGS IN DOCTOR DRAFT

THE AMA WASHINGTON LETTER NO. 7, FEBRUARY 13, 1953

1. All registrants except those in the present Priorities I and II to be divided into two groups. *First* to be taken, those with no military service, who would be inducted by age, with the youngest going first. *Next*, those who have had active duty, with those having the least active duty inducted first. (Those remaining in the present Priorities I and II to be called immediately on expiration of deferrals.)

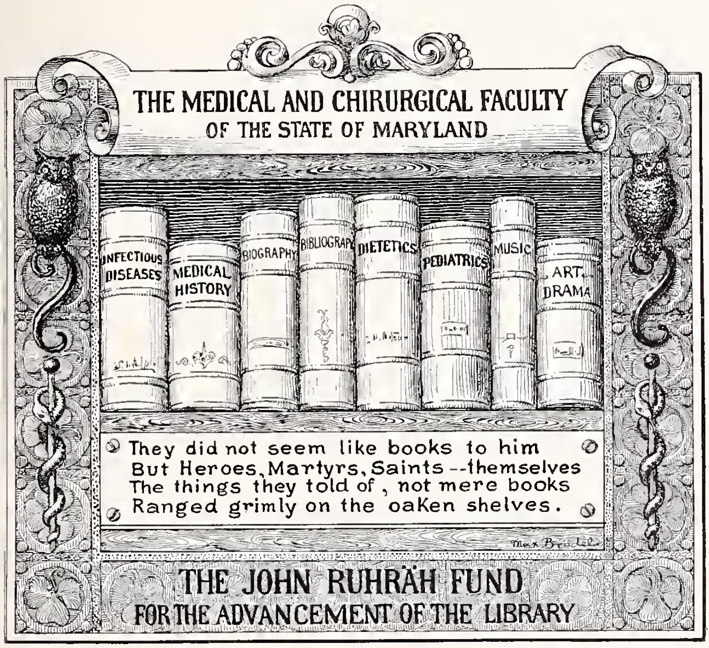
2. Maximum age for inductions would be maintained at 51. (A lower maximum had been discussed informally.)

3. Men called to duty as reservists would be commissioned in grades "commensurate with professional education, experience or ability;" in other words, current arbitrary limitations on numbers of higher commissions would be waived in case of medical officers.

4. Other provisions—law to expire July 1, 1955; National and State Advisory Committees continued and strengthened; World War II service with cobelligerents recognized for purposes of Doctor Draft; $100 special pay not disturbed. Reserve commissions would terminate upon completion of stipulated active service.

Library

THE JOHN RUHRÄH FUND


THE MEDICAL AND CHIRURGICAL FACULTY
OF THE STATE OF MARYLAND
INFECTIOUS DISEASES
MEDICAL HISTORY
BIOGRAPHY
BIBLIOGRAPHY
DIETETICS
PEDIATRICS
MUSIC
ART DRAMA
They did not seem like books to him
But Heroes, Martyrs, Saints --themselves
The things they told of, not mere books
Ranged grimly on the oaKen shelves.
Max Brödel
THE JOHN RUHRÄH FUND
FOR THE ADVANCEMENT OF THE LIBRARY

Dr. John Ruhräh, a world-renowned pediatrician, a world traveler and a profound scholar, was born on September 26, 1872, at Chillicothe, Ohio. He was the son of Daniel Conrad and Mary Fincknauer Ruhräh. The unusual family name was traced to an abbreviation of Ruhrahn, indicating that the first of that name came from the Ruhr Valley. His father was a native of Bremen, Germany. His maternal grandparents were Baltimoreans and so it was to this city that he came to complete his education.

In 1894, he received his degree of Doctor of Medicine from the College of Physicians & Surgeons of Baltimore and joined the staff of Mercy Hospital, where he served as Resident Physician until 1897. He then went abroad to study at the Pasteur Institute in Paris. Returning to Baltimore, he spent a year as Physician-in-Charge of the Pasteur Department of the College of Physicians & Surgeons. Then, he became the Quarantine Physician of the Port of Baltimore, serving until 1900, when he returned to Europe for postgraduate work at the universities of Berlin, Vienna, Paris and London.

Entering private practice in Baltimore in 1901, he maintained his academic connection with the College of Physicians & Surgeons. After the merger with the University of Maryland Medical School, he joined the faculty as Professor of Diseases of Children.

As a member of the Medical and Chirurgical Faculty, he served as Secretary from 1907 to 1917, as President in 1919; and, later, as Chairman of the Library Committee.

His Presidential Address to the Faculty on April 22, 1918, was on the subject of the medical library. Not only did Dr. Ruhräh review the history of the library but he also stressed the value of a medical library to the physician, the outlook for its future and the hope of every scholar that the library will rightfully take its place as an important school where one can commune with the old and new masters. He made a plea to the members not to let history repeat its past errors and let the fate of the Faculty in 1860 be a warning for all to hold the torch on high. He counseled his listeners to remember that "we can only give the profession the opportunity to use the splendid collection of books at their disposal. We cannot drive them to the Pierian spring, much less make them drink deeply of it; but those of us who have labored in the interest of the Library, and of medical libraries in general, at least have the great satisfaction of knowing that we have paved the way for the profession, and if they persist in straying in the bypaths, instead of on the broad highway of knowledge, we can only point again and again at the sign board with the finger pointed to SUCCESS. For it means success to be well informed. Look about at the most successful medical men, successful in the real sense of the word, and you at once see that they are successful because they know."

Dr. Ruhräh was as much at home in the printed world as in the field of medicine for he was not only interested in medical books but also had a wide knowledge of books. His bookshelves in his home were filled to capacity with first editions, language dictionaries, volumes of verse, essays and philosophy. Many were in German, Spanish, French and Italian. One of his greatest sources of pleasure was that which he found in his complete set of the *Oxford English Dictionary*. He often said that the only thing he feared was that he would not live long enough to learn what was in those twenty volumes. Another favorite book was Pepys' *Diary*, which he recommended to those who talked about hard times. His copy of Stevenson's *Home Book of Verse* was always at hand. He had memorized the famous children poems and delighted in recalling them.

Dr. Ruhräh not only found interest in his profession and the literary world but also in the letters, music, drama and painting. He had a standing order for seats for every worthwhile event at the Lyric and he seldom missed an important first night at the theatres. He planned his annual trips abroad so that they would include one or more of the summer music festivals. He lived modestly but his adventures in eating led him from restaurant to restaurant in every corner of the world. Explaining his adventures in Baltimore, he replied that he was searching for some restaurant which supplied food as good as Baltimore used to boast; but he was never able to find that paradise.

Dr. Ruhräh had a bedside manner that came from long experience. It was fortified by study, understanding and a personal interest in his patients. He was a great diagnostician. In successfully treating a case, it has been said that he cured the child as well as the parents by instilling confidence in the bewildered and frightened parents, who borrowed strength and courage from him in their time of need.

Dr. William Osler regarded him to be one of the most brilliant of the younger men and showed him the way to the heights. This great inspiration was with Dr. Ruhräh to the end. It interested him in the history of medicine and opened the doors of the libraries of the world. It gave him an incentive to write and his writings were in constant demand. Dr. Ruhräh was a fluent writer. He edited two volumes: "Pediatrics of the Past, An Anthology," which is a source book of unusual interest and merit, and "William Cadoza: His Essay on Gout." With Dr. Julius Friedenwald, he collaborated in writing "Diet in Health and Disease" and "Dietetics for Nurses." Alone, he wrote a "Manual of Diseases of Infants and Children." With Dr. E. E. Mayer, he wrote "Poliomyelitis," which is regarded to be one of the standard treatises on the disease. In addition to these medical writings, he was a frequent contributor to the *Sunpapers*, reviewing books and plays, writing feature articles and poetry and criticizing musical programs.

Dr. Ruhräh was interested in anything that was worthwhile. He admired knowledge but preferred practicability. In his estimation, ability and common sense were the most valuable gifts of man.

While in Naples in 1930, he was stricken with poliomyelitis, a disease which seriously damaged his body but left his mind untouched. Although he was alone in a strange land and paralyzed, he started taking lessons in Italian from his native nurse as soon as he recovered his speech. Before he came home, he was reading Dante in the original. During his stay in the hospital, he studied Russian, advanced Spanish and reviewed his Latin. Upon his return home, he entered Mercy Hospital and later went to Warm Springs, Georgia, where he responded to treatment. His determination to get well and his ready wit were always with him. Much to the astonishment of his associates, he assumed his professional duties, his literary activities and interest in the municipal affairs of Baltimore.

In October of 1934, he went to Texas with the intention of going to Mexico for sightseeing and studying conditions from every angle but illness prevented him from carrying out his plans. Returning to Baltimore, his death occurred on March 10, 1935.

According to his will, Dr. Ruhräh left most of his library to the Medical and Chirurgical Faculty. As a tribute to his loyal devotion to the Faculty and the wish to preserve his heritage, the John Ruhräh Memorial Room was dedicated on April 29, 1936. This Room houses the cultural books from Dr. Ruhräh's library, which he bequeathed to the Faculty. In addition to his library, Dr. Ruhräh left his estate to relatives but with the provision that its residue will go to the Faculty on the death of the legatees. Upon the death of one of the beneficiaries, the Faculty received one-third of the corpus of the estate, and the balance of two-thirds will be received after the other two beneficiaries die. He further directed that the Library Committee of the Faculty shall have control of the income to be used as directed by the will so that "the Library needs be considered first of all."

The Ruhräh Fund bookplate was designed by Max Brödel, who followed the instructions which Dr. Ruhräh left in a letter addressed to the Faculty. He directed that the design suggest a row of books on a shelf with each book bearing the title of the subjects in which he had been particularly interested.

"Rich as was this man's life, it was far too short for all the things his great spirit had to do."—Editorial—*Morning Sun*—March 11, 1935.

REFERENCES

Chappelear, F. D., Dedication of the John Ruhräh Memorial Room, Med. Chir. Fac. Maryland **138:** 14–18, 1936

Cooley, T. B., President's address, J. Pediat. **7:** 1, 1935

[Medical and Chirurgical Faculty], Resolution adopted by the Council, Med. Chir. Fac. Maryland **138:** 23, 1936

Ruhräh, John, Copy of letter left for the Faculty . . . Last will and testament, Med. Chir. Fac. Maryland **138:** 18–22, 1936

Ruhräh, John, The Medical library, Bull. Med. Chir. Fac. Maryland **11:** 148–157, 1919

Weisberger, Siegfried, Doctor Ruhräh at home, Bull. M. Library A. **24:** 186–191, 1936

HAVE YOU PAID YOUR AMERICAN MEDICAL ASSOCIATION DUES?

The American Medical Association Annual Session will be held in New York City from June 1 to June 5, 1953. The headquarters, Scientific and Technical Exhibits, and other meetings will be at the Grand Central Palace, 44th and Lexington Avenues.

To avoid the usual congestion at the registration windows and to save yourself trouble and delay, the American Medical Association is issuing advance-registration cards which will make it possible to quickly register instead of waiting in line to have your record checked with the membership roster.

To register it is necessary for you to have a pocket card showing your membership dues in the American Medical Association paid for 1953.

If you have not already sent in your check to cover 1953, we suggest that you do so at once, so as to give us an opportunity to forward the payment to the A.M.A. in time to have the A.M.A. issue a pocket card and also an advance-registration card to you.

State of Maryland Department of Health

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, February 27–March 26, 1953

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCAL	MUMPS	POLIOMYELITIS, PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS
																		Influenza and pneumonia
Total, 4 weeks																		
Local areas																		
Baltimore County	94	—	8	4	4	—	23	—	—	118	—	—	2	19	1	11	—	3
Anne Arundel	18	—	2	1	7	—	7	—	—	15	—	—	—	1	—	3	—	7
Howard	1	—	—	—	2	—	—	—	—	1	—	—	1	—	—	—	—	—
Harford	12	—	69	3	2	—	4	—	—	6	—	—	—	2	—	2	m-1	—
Carroll	6	—	—	7	4	—	—	—	—	—	—	—	—	4	—	—	—	1
Frederick	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	2
Washington	—	—	—	—	—	—	—	—	—	—	—	—	—	6	—	3	—	1
Allegany	8	—	—	4	10	1	1	—	—	4	—	—	—	6	—	1	—	2
Garrett	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	2
Montgomery	43	—	11	1	10	3	22	—	—	11	—	—	—	13	—	5	—	3
Pr. George's	28	—	3	6	8	—	20	—	—	11	—	—	—	11	—	2	—	2
Calvert	—	—	—	—	1	—	1	—	—	—	—	—	—	1	—	—	—	—
Charles	—	—	—	—	—	—	1	—	—	—	—	—	—	1	—	—	—	—
Saint Mary's	1	—	—	3	—	—	—	—	—	—	—	—	—	—	—	2	—	1
Cecil	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	1	—	—
Kent	16	—	136	—	10	—	6	—	—	44	—	—	—	—	—	—	—	—
Queen Anne's	—	—	1	—	4	1	1	—	—	4	—	—	—	1	2	—	—	2
Caroline	—	—	—	—	—	—	2	—	—	2	—	—	—	3	—	5	—	—
Talbot	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3
Dorchester	6	—	—	—	1	—	5	—	—	—	—	—	1	2	—	6	—	—
Wicomico	11	—	1	—	—	—	—	—	—	1	—	—	—	4	—	8	r-1	—
Worcester	2	—	—	—	—	—	—	—	—	—	—	—	—	3	1	—	r-6	1
Somerset	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2
Total Counties	247	0	231	29	63	5	93	0	0	218	0	0	4	77	5	52	—	32
Baltimore City	246	0	85	2	44	3	143	0	0	244	1	0	12	99	8	497	—	32
State																		
Feb. 27–Mar. 26, 1953	493	0	316	31	107	8	236	0	0	462	1	0	16	176	13	549	—	64
Same period 1952	412	1	209	16	1890	13	105	1	0	163	0	0	8	250	7	487	—	126
5-year median	561	10	83	—	590	12	243	0	0	167	2	5	55	223	90	502	—	87
Cumulative totals																		
State																		
Year 1953 to date	1537	6	499	119	240	36	470	2	0	992	3	2	60	583	38	1793	—	331
Same period 1952	1271	4	277	83	5803	29	380	6	0	433	6	8	47	658	33	1470	—	244
5-year median	1427	28	133	—	1270	31	600	1	0	450	4	13	213	606	261	1575	—	235

m = malaria reported by Aberdeen Proving Grounds, origin in Korea, home residence not stated.

r = positive rabies in animals.

Streptococcal infections: There has been a marked rise in the number of reported cases during the month of March. Prevent Rheumatic Fever!

BLUE CROSS AND BLUE SHIELD

MARYLAND HOSPITAL SERVICE, INC.

R. H. DABNEY*

Maryland Hospital Service set new records in 1952—a new high mark in enrollment, in subscription income, in patients hospitalized and in payment to member hospitals. Despite this growth, the Plan operated at a loss for the second year in a row, and had to draw substantially on its subscriber reserves to meet expenses. This experience was typical of many Blue Cross Plans in 1952, and explains why we and others have had to increase subscription charges.

There are several apparent reasons for this. Hospital costs have continued upward; more subscribers are using more care; and operating costs have increased slightly. But there are hidden reasons too—reasons more basic, more fundamental, and not so easily understood.

Just what is Blue Cross? It is a non-profit voluntary prepayment program to provide health services to the self-supporting population in our community. Stated another way, Blue Cross is a means of removing the financial barriers to health services, organized and sponsored by the suppliers of those health services—the hospitals and the doctors.

Blue Cross is not an insurance company. It operates on many of the time-tested insurance principles, but at the same time disregards others in attempting to provide a service to the entire community, not to just a selected segment of the community. Unlike commercial insurance companies, we take small groups and big; we don't ferret our bad risks by health statements; we charge all groups the same premium regardless of size, type of industry, sex or age of employees—a community rate if you will; we permit continued coverage after leaving an employed group, including retired persons; we don't cancel groups or individuals who are bad risks.

Blue Cross is expected to provide a service to the whole community—that is why it is given a preferred status as a non-profit, tax-free corporation. But is it attempting the impossible in providing a social need and not adhering completely to sound insurance practice?

I don't profess to know the final answer, but I am willing to believe that it can be done, that Blue Cross can move ahead and fulfill its stated community function successfully. But it can be done only if all are willing to bend every effort to make it work.

First, we must intensify our enrollment efforts to produce better selection and better operating experience. I believe we need to spend more money and effort on sales promotion and public education—particularly the latter; to stimulate a wave of public support, support from management and labor as well as the individual subscriber. This can only be done with strong backing from hospitals and from the medical profession.

Secondly, we must have complete cooperation and support from the hospitals and the doctors in conserving Blue Cross resources through the control of costs and the elimination of unnecessary hospital admissions and services. Particularly, the medical profession must understand its basic relationship and responsibility to Blue Cross; *they must understand that the whole economy of our operation is a matter of individual doctor determination.* They must understand that because of the "nature of our beast," an extra day's stay, an additional admission which could be treated outside a hospital, one extra laboratory test or an additional drug administration, may spell the end of our ability to provide a service to the community—and may bring on the socialization of health services. And these controls toward conservation of resources, cannot be achieved by regulation from our office. The responsibility must be placed squarely on the treating physician—and on the hospital. All Blue Cross can do is widen the understanding of the problem.

Finally, Blue Cross, the hospitals and the physicians together, must educate the public to spend an increasing proportion of their total income for health services. That hospital and medical costs have risen substantially over the past 10 years, no one will deny; but they have not risen out of proportion to the value of other services and commodities, and the quality of care has improved vastly. I frankly see little hope for a change in the upward trend of hospital costs.

---

*Resume of Report by R. H. Dabney, Director of Maryland Hospital Service, Inc., at the Annual Meeting of Corporation, January 27, 1953.

Blue Cross has met a real public need in the past 15 years, as any of its 43 million subscribers in the nation will testify. Its job has become more complex with its growth and major problems need to be solved. The future requires careful and thoughtful planning and direction, but most of all, understanding and teamwork on the part of all concerned. I believe it can move ahead—and I hope you agree with me.

BALTIMORE CHAPTER: THE AMERICAN RED CROSS

The Baltimore Chapter, American Red Cross, is in need of part time physicians, to be paid on a per diem basis, to cover blood donor operations at odd hours. If interested please contact Dr. Hernandez, Medical Director, HOpkins 9905, or by letter—Baltimore Chapter, American Red Cross, St. Paul and Twenty-third Streets.

ODM TO HANDLE GAMMA GLOBULIN DISTRIBUTION

THE AMA WASHINGTON LETTER NO. 7, FEBRUARY 13, 1953

The Office of Defense Mobilization has taken over responsibility for distribution of gamma globulin for use in treatment of paralytic poliomyelitis, infectious hepatitis and measles. Details of distribution are being evolved by a National Research Council committee of physicians. It is understood the plan contemplates distribution of the central supply of gamma globulin to State Health Officers, who will be responsible for its final local use.

POSITION AVAILABLE

There will be an examination for the opening for Chief Medical Director of the Board of Education of the City of New York. Fifteen hours of service per week. Maximum age—50 years.

For details write to Jacob Greenberg, Associate Superintendent, Board of Education of the City of New York, 110 Livingston Street, Brooklyn 2, New York.

Ancillary News

NURSING SECTION

M. RUTH MOUBRAY, R.N., *Executive Secretary,*
Maryland State Nurses Association
Journal Representative

MARYLAND STATE BOARD OF EXAMINERS OF NURSES REPORT TO THE MARYLAND STATE NURSES' ASSOCIATION FOR THE YEAR 1952

We are submitting the following report of the major activities of the Maryland State Board of Examiners of Nurses during 1952.

Four basic collegiate programs in nursing have opened in Maryland at:

Washington Missionary College	Takoma Park
St. Joseph College	Emmitsburg
Mount St. Agnes College	Baltimore
University of Maryland	

These are all 4 year programs. Degrees in nursing will be granted by the colleges. The patterns are all different and will not be described in this report.

Including these, there are now 24 basic collegiate and hospital programs in nursing in Maryland. The University of Maryland offers both the basic collegiate (4 year program) and the hospital program (3 years).

A more liberal interpretation by the Attorney General of the section in the law relating to nursing makes it possible for students to receive more credit in time in a 3 year program (required by the law) for college work.

The colleges in turn agreed to accept approved nursing practice in hospitals and other health agencies towards requirements for their degrees. In general these were the fundamental adjustments it was necessary to make in order for the Board of Examiners to be able to approve the programs and accept the graduates for licensure as registered nurses.

During the year the Board has approved affiliations in Tuberculosis Nursing at the Baltimore City Hospitals and in Psychiatric Nursing at the Spring Grove State Hospital.

The Board of Examiners cooperated with the National Nursing Accrediting Service. The programs in all the schools of nursing in Maryland in 1951 that had not been fully accredited were reviewed by the National Nursing Accrediting Service.

There were 21 schools in Maryland in 1951—
4 had been fully accredited previously
15 were temporarily accredited in 1952

The goal is full accreditation of all the programs within a 5 year period.

At the request of the Board of Examiners of Nurses, the Maryland League for Nursing made recommendations to the Board relating to the programs in schools of nursing. The study of the recommendations by the Board has been completed and the material is in the hands of the printer. The Board appreciated the cooperation and suggestions of the League and the members of the various committees who contributed so helpfully to this project.

The terms of two Board members, Mrs. Dorothy F. McBride, President, and Sister Mary Vincent Dunnigan, Secretary-Treasurer, expired in May 1952. The Board regretted that neither member felt it was possible to continue. We welcome the two new members, Mrs. Bessie W. Parr, Educational Director, Maryland General Hospital School of Nursing, and Sister Katherine Marie Sump, Nursing Arts Instructor, St. Joseph's Hospital School of Nursing. Mrs. Elizabeth F. Norwood was elected President and Miss Irene M. Duffy, Secretary-Treasurer.

Standard Scores are now used in reporting State Board examination results. Information concerning the scoring and reporting of State Board Examinations was sent to the schools of nursing.

Following a study of scores and failures in the six subjects, the Maryland Board of Examiners decided to set the standard score 350 as passing in each subject. The studies indicated that this will mean a slight advantage to candidates.

This use of 350 passing score may facilitate interstate registration when it becomes possible for more states to use this passing score. It also enables the Board to use the new plan of the Test Pool Committee for reporting scores to candidates and schools. This will eliminate a great amount of clerical work in the Board office which in turn will mean more prompt reports to candidates and will speed up the process of registration.

During 1952, State Board Test Pool examinations have been used for Licensed Practical Nurse examinations. Beginning in January 1953, all candidates for licensure as Licensed Practical Nurse must meet requirements in the curriculum issued by the Board of Examiners for Licensed Practical Nurse schools (1950) except the practice in Obstetric Nursing.

There are now 9 approved schools for practical nurses in Maryland:

Baltimore City Hospitals	Baltimore
South Baltimore General Hospital	Baltimore
Cambridge-Maryland Hospital	Cambridge
Eastern Shore State Hospital	Cambridge
(Classes have not started)	
Henryton State Hospital	Henryton
Rosewood State Training School	Owings Mills
Victor Cullen State Hospital	Sanatorium
Crownsville State Hospital	Crownsville
Springfield State Hospital	Sykesville

The school at the Home for Incurables, Baltimore, Md., closed September 1952.

A re-interpretation of the provision in the law relating to credit in time in the 3 year course in nursing was made by the Attorney General.

Credit in time up to 8 months in the 3 year course may be granted by the school of nursing to a licensed practical nurse who has graduated from a school of practical nursing that is approved by the Board of Examiners of Nurses in the state where the school is located or by the National Association for Practical Nurse Education. No course credits for the practical nurse program would be granted. The student would complete the courses of instruction and weeks of experience in the various services required for registration as a graduate nurse and be granted credit in time at the end of her program. All decisions about admission of the students, the details of their program and the amount of credit in time are to be made by the school of nursing.

The total number of Maryland Registered Nurses to date (1904 to Dec. 31, 1952) inclusive, is 21,294.

The total number of graduate nurses registered from January 1, 1952, to December 31, 1952, is 1,203. Of this number 857 were registered with examination and 346 by Inter-state Registration. Note: 372 of the Passed Candidates of the October 1951 Examination were not registered until January 23, 1952.

There have been three (3) regular examinations for State registration in the year 1952 with the total enrollment of first examination candidates—568 and re-examination candidates—180 (the combined total of 748).

April 15–16, 1952 (Osler Hall, 1211 Cathedral Street, Baltimore, Md.)

		Passed	Failed	Absent
1st exam. candidates	82	60	20	2
re-exam. candidates	89	50	37	2
	171	110	57	4

June 24–25, 1952 (Osler Hall, 1211 Cathedral Street, Baltimore, Md.)

		Passed	Failed	Absent
1st exam. candidates	73	66	6	1
re-exam. candidates	52	26	22	4
	125	92	28	5

October 21–22, 1952 (The Alcazar, Cathedral and Madison Sts., Baltimore, Md.)

		Passed	Failed	Absent
1st exam. candidates	413	331	79	3
re-exam. candidates	39	20	17	2
	452	351	96	5

Our Board has registered by Inter-state Registration in the past year (Jan. 1, 1952, to Dec. 31, 1952) three hundred and forty-six (346) nurses:

1 each from the following States: Arkansas, Idaho, Kansas, Montana, New Hampshire, Rhode Island and Utah.
2 each from: Georgia, Iowa, Kentucky, Louisiana, Maine, Nebraska, South Dakota, Wis.
3 each from: Colorado, Washington State
4 each from: Florida, Minnesota, Missouri, Oregon, South Carolina
5 each from: Texas and Vermont
6 each from: Connecticut, Indiana, Tennessee

7 from: Michigan
8 from: Delaware
9 each from: Illinois, New Jersey
10 from: Ohio
11 from: California
13 each from: Massachusetts, West Virginia
16 from: North Carolina
17 from: Virginia
22 from: District of Columbia
46 from: New York
73 from: Pennsylvania
14 from: Canada
1 from: Philippine Islands

In 1952, 692 students were admitted to schools of nursing in Maryland. On December 31, 1952, there were 1,785 students in the schools.

Total Enrollment (1952)	1,785
Total Enrollment (1951)	1,839
Showing a decrease of—	54

Licensed Practical Nurse Department

The total number of Maryland Practical Nurse Licenses issued to date (Dec. 1922 to December 31, 1952) is 2,814. Original licenses issued in 1952 were 202. Licensed Practical Nurse renewals for the year 1952 were 1,154. Therefore, the total number licensed for 1952 was 1,356.

Three (3) regular examinations for practical nurses and one (1) special examination for re-examination candidates only were held during 1952:

		Passed	Failed	Absent
Feb. 2, 1952 (Special Exam. held at Mercy Hospital)				
re-exam. candidates...	12	11	1	0
April 16, 1952 (Osler Hall)				
1st exam. candidates..	95	86	7	2
re-exam. candidate....	1	1	0	0
	—	—	–	–
	96	87	7	2
June 25, 1952 (Osler Hall)				
1st exam. candidates..	14	12	0	2
re-exam. candidates...	4	2	1	1
	—	—	–	–
	18	14	1	3
October 22, 1952 (The Alcazar)				
1st exam. candidates..	96	90	5	1
re-exam. candidates...	1	0	1	0
	—	—	–	–
	97	90	6	1

(Mrs.) Elizabeth F. Norwood, R.N.,
President

* * * * *

VOLUNTARY PENSION PLANS[*]

The following is a simplified explanation of the bills which have been introduced to provide tax deferments on amounts paid to purchase retirement annuities. These bills (H.R. 10 and H.R. 11, 83rd Congress) are now pending before the Ways and Means Committee of the House of Representatives.

In December 1952 the House of Delegates of the American Medical Association reaffirmed its position advocating the enactment of legislation of this type.

During the first week of the 83d Congress bills were again introduced to permit tax deferments on amounts used to purchase retirement annuities. These measures, H.R. 10 and H.R. 11, which were introduced by Mr. Jenkins of Ohio and Mr. Keogh of New York, are identical with the "Keogh-Reed" bills of the 82d Congress. The bills are designed to encourage the establishment of voluntary pension plans by individuals and to provide more equitable tax treatment for self-employed persons. The bills in their present form now include all the amendments suggested by the American Medical Association at hearings on the original legislation last May.

Through amendment of the Federal Internal Revenue Code, the bills would allow physicians and other self-employed individuals to deduct from their taxable income those amounts used each year to finance restricted retirement plans. Employed persons not covered by existing pension plans also would qualify for the tax deduction privilege.

Income received later during the years of retirement, either from pension funds or insurance annuities, would then be taxable under the prevailing rates. In other words, they provide tax deferment but not tax avoidance.

---

[*] Committee on Legislation of the American Medical Association.

Physicians, dentists, lawyers, architects, farmers, store owners and the many others who comprise the nation's self-employed have long been neglected in federal tax legislation relating to pensions. The purpose of these bills is to eliminate the discrimination and inequities existing under present tax laws. By extending the tax deferment privilege to the country's ten million self-employed, and also to millions of employees who are not covered by pension plans, this new legislation will give them the incentive to save for old age during their best earning years.

Under Section 165 (a) of the 1942 Revenue Act, millions of employees covered by more than 16,000 approved pension plans are already receiving the benefit of pension tax deferment. They pay no tax during their working years on the employer's contribution to their retirement fund, even though it actually is extra compensation to the employee. After he retires, however, the employee must pay the tax on the part of the retirement benefit which was financed by the employer.

To provide a similar tax arrangement for self-employed persons, the bills would allow annual deductions of 10 per cent of earned net income, or $7,500, whichever is smaller. Total deductions during a taxpayer's lifetime could not exceed $150,000. The funds excluded from taxable income would have to be paid either to a trust fund established by an association for the benefit of its members or to an insurance company as premiums for a retirement annuity contract. In either case, no income payments or cash refunds could be made before the age of 65 except in cases of total disability or death.

The bills include a provision enabling persons already between the ages of 55 and 75 to make larger annual deductions than the basic 10 per cent or $7,500. This is a practical equivalent to the past service credits allowed in many employee pension plans. The bills also provide for a carry-over of unused deductions for a period up to five years. This is designed to give equitable treatment to persons with extreme fluctuations in income.

This legislation will be of particular benefit to physicians who go through a long and costly period of training and whose peak earnings are bunched into a comparatively short period of years when they are subject to high income tax rates.

This legislation, which has the approval of the American Medical Association and twenty other national organizations, can be enacted by the 83d Congress if physicians and all other self-employed persons work actively together for its passage.

Maryland Academy of General Practice

President—Harold Plummer, M.D., Preston
President-Elect—Lauriston L. Keown, M.D., 1938 Linden Ave., Baltimore
Secretary-Treasurer—Nathan E. Needle, M.D., 4215 Park Heights Ave., Baltimore
Vice-Presidents—B. B. Kneisley, M.D., Hagerstown
Geo. A. Knipp, M.D., 4116 Edmondson Ave., Baltimore
Norman E. Sartorius, Jr., M.D., Pocomoke City
Executive Secretary—Mr. Wm. J. Wiscott, 1818 Ashburton St., Baltimore

POST-GRADUATE STUDY REQUIREMENTS FOR REGULAR AND ASSOCIATE MEMBERS

1. *What are they?*
   150 hours over each 3 years, 50 hours of which must be obtained from formal post-graduate studies.
2. *What is meant by "Formal" Post-Graduate Studies?*
   A. Courses sponsored and presented as such by medical teaching institutions.
   B. Courses sponsored as such by the Maryland or American Academy.
   C. Various courses throughout the state may be specifically approved as such by the Board of Directors of the Maryland Academy.
   D. Certain courses over the nation may be approved by the American Academy.
   E. Courses out of the state approved as such by the Maryland Academy.
   F. Annual meeting of the American Academy of General Practice.
   G. The annual meeting and Scientific Assembly of the Maryland Academy.
3. *What is included in the 100 hours of Non-Formal Post-Graduate Studies?*
   A. Hospital staff meetings and clinicopathologic conferences.
   B. County, district or state medical society scientific meetings.
   C. A.M.A. or other scientific medical meetings drawing attendance from the nation or a large district.
   D. Scientific medical meetings of study clubs or various state groups.
   E. Cancer society or Heart association scientific meetings.
   F. All other scientific medical meetings.
4. *How is the Time Credit figured?*
   On a clock-hour basis unless a definite accredited time has been designated by the approving body. In the latter case, official credit is announced.
5. *How difficult is it for a busy general practitioner to meet these requirements?*
   An average of 16⅔ hours formal study and 33⅓ hours of non-formal post-graduate studies a year is easily attained.
   The annual meeting and Scientific Assembly of the Maryland Academy will give 8 hours formal credit.
   The spring meeting and Scientific Assembly and the spring and fall seminars each will give a minimum of 4 hours formal credit.
   Attendance at 9 hospital staff meetings of 1 hour each, 9 county or city meetings of 1 hour each or more, depending upon the number of speakers and time allotted to each, and the annual meeting of the Medical and Chirurgical Faculty of Maryland will cover the 33⅓ hours of non-formal post-graduate study.

CLOSED CIRCUIT TELECAST—UNIVERSITY HOSPITAL

A limited number of members of the Maryland Academy participated in a post-graduate televison clinical session held in Gordon Wilson Hall, University Hospital, Thursday, January 15. The program was presented under the auspices of the Post-Graduate Committee of the School of Medicine and in cooperation with the staff of WBAL-TV.

Beginning promptly at 8:50 A.M. with some music, a brief introduction started the program at 9 o'clock, and except for one hour for lunch, it continued through 36 sequences, ending at 5:00 P.M. It was designed to present to the general practitioner a full day of clinical instruction, including instructions and demonstration of microscope slides, detailed operative instruction from the operating room, and demonstrations of patients in the various clinics. The viewers were able to follow the instructions and demonstrations in a relaxed atmosphere. At times the program was interspersed with music.

The telecast demonstrated the possibilities provided by a closed circuit micro-wave to transmit clinical instruction to remotely situated Maryland physicians from the University. It also showed it was possible to include a return audience circuit directly to the studio, thus enabling the audience to ask questions of the speaker or demonstrator. At one point in the program a 15-minute broadcast from WBAL-TV was transmitted to the hall. This demonstrated the possibility of including in any telecast, programs from more than one source. In fact, the entire program as used, was picked up from a total of four separate studios.

The committee in charge of arrangements included Dr. Howard M. Bubert, Dr. John A. Wagner and Mr. George Buck from the School of Medicine and University Hospital, and Messrs. D. L. Provost, John Wilner, Bob Jones, Lewis Wagner, Raymond Brunner and William C. Bareham from WBAL-TV.

The program was designed to include a diversity of medical subjects. In general, they fell into three main groups: objective clinics, clinico-pathologic science demonstrations and round tables or symposia. A total of 29 members of the teaching staff participated in presenting 14 different medical conditions.

In addition to the limited number of members of the Maryland Academy, members of the county medical societies, city medical societies, faculty heads, President H. Clifton Byrd and several members of the Board of Regents of the University of Maryland were present.

SPRING SCIENTIFIC ASSEMBLY

May 14, 1953

Cardiovascular diseases will be the subject discussed at our Spring Scientific Assembly. Because of the cooperation of the Heart Association of Maryland, we are able to participate in an exceptional program. An all-day session on heart diseases will be held in the Administration Building of the National Health Institute, Bethesda, on May 14th, from 9:00 A.M. to 4:30 P.M.

The following tentative program has been arranged by the committee headed by Dr. Nathan E. Needle and Dr. Lauriston L. Keown of the Academy, and Dr. Helen B. Taussig, *President*, and Dr. William S. Love, Jr., *Chairman of the Program Committee*, of the Heart Association.

9:00–10:00—Registration
10:00–10:40—Clinic Patient Demonstration:
    Dr. Helen B. Taussig,
    Associate Professor Pediatrics, Head of Heart Department, Harriet Lane Home, Johns Hopkins Hospital
    Dr. William S. Love,
    Associate Professor of Medicine and Head of Cardiology Department, University of Maryland, School of Medicine
    Dr. E. Cowles Andrus,
    Associate Professor of Medicine, Johns Hopkins Medical School
Morning session—Dr. Harold Plummer, *President, Maryland Academy of General Practice*, presiding
10:40–11:20—Hypertension:
    Dr. Caroline Thomas,
    Associate in Medicine, Johns Hopkins Medical School
11:20–12:00—Cardiac Emergency:
    Dr. Maurice C. Pincoffs,
    Professor and Head of the Department of Medicine, University of Maryland, School of Medicine
12:00–12:30—Question Period
12:30– 2:00—Luncheon Recess—(Reservation must be made in advance)
2:00– 2:40—The Clinical Evaluation of Treatment of Occlusive Arterial Diseases:
    Dr. Irving S. Wright,
    Professor of Clinical Medicine, Cornell University Medical School
2:40– 3:20—Congestive Heart Failure:
    Dr. Robert L. Levy,
    Professor of Clinical Medicine, College of Physicians and Surgeons, Columbia University
3:20– 4:00—Coronary Thrombosis and Angina Pectoris:
    Dr. Paul D. White,
    Former Clinical Professor of Medicine, Harvard Medical School
4:00– 4:30—Question period.

This tentative program may be subject to revision. It is hoped that a tour of the National Health Institute may be included. Copies of the complete program will be mailed to you.

The importance of this Spring Assembly, because of its subject and the outstanding authorities who will participate, makes it a "must" for every member of the Academy. Invite your colleagues to attend. This Assembly is not closed session but is open to all physicians in Maryland. The only request is that those who wish luncheons shall notify your secretary or the secretary of the Heart Association of Maryland, 32 East 25th Street, Baltimore 18.

NEW MEMBERS

Since our Annual Meeting the following physicians have been elected into *Active* membership:

G. J. Weems, Huntingtown
Catherine V. Kemp, 1300 Wildwood Pkwy., Baltimore
Richard Anthony Yates, Olney
Nathan R. Thomas, Ocean City
Emily H. Wilson, Lothian
Malcolm Dudley Phillips, Darlington
Max R. English, 5713 Belair Rd., Baltimore

The following have become *Associate* members:

Frank T. Kasik, Jr., Parkville
Frederick P. Sheppard, Queenstown
Irving G. Hoyt, Queenstown
Andrew C. Marshall, Salisbury

Jesse O. Purvis, Annapolis, was elected to *Emeritus* membership.

ELECTION OF MEMBERS

The constitution of the Maryland Academy provides that members of the Medical and Chirurgical Society of the State of Maryland shall be eligible for membership. Application for membership shall be made in writing. Election to membership shall be by the majority of the Board of Directors.

MEMBERSHIP COMMITTEE FOR 1953

Chairman—Merrill Cross, 8248 Georgia Ave.,
Silver Spring

Henry L. Fahrney, Frederick
James Frenkil, 1422 Park Ave., Baltimore
B. L. Grant, Shadyside
Rodney Layton, Centreville
Martin Buell, Easton
Hugh Ward, Owings
B. B. Kneisley, Hagerstown
Norman Sartorius, Pocomoke City
George Burgtorf, Ellicott City
Martin Rothstein, Frostburg
Allen Maulton, Westminster
Eldridge Wolff, Cambridge
Roy Guyther, Mechanicville
William Gray, Salisbury
Sarah Peyton, Crisfield
William Brainin, Capitol Heights

MARYLAND AND D. C. MEETING

A joint meeting of the Maryland and District of Columbia Academies will be held on April 23rd. Plans for the program are now being worked out by Dr. Merrill Cross and a committee from the District Academy. This meeting promises to be an important one. Complete details will be mailed later.

* * * * * *

THE ROLE OF THE BALTIMORE CITY MEDICAL SOCIETY IN THE REORGANIZATION AND APPROVAL OF DOCTORS HOSPITAL

WILLIAM SCHUMAN, M.D.

The Board of Trustees of Doctors Hospital and the Executive Committee of the Baltimore City Medical Society have announced the approval of the hospital by the Council on Medical Education and Hospitals of the American Medical Association on December 1, 1952.

The accreditation of the hospital is the result of a plan of reorganization which began in 1949, two years after the erection of the hospital on its North Charles Street site by a small group of local physicians. Control of the new institution was transferred from its founders to a Board of Trustees composed of laymen with no financial interest in the hospital.

In November 1949, the writer requested the permission of the Board of Trustees to arrange for a professional survey of the hospital, with particular emphasis on surgery. This authority was given, and the initial step was the enlisting of the voluntary services of Dr. Ross Z. Pierpont to direct such a survey. Dr. Pierpont obtained the assistance of Doctors Donald B. Hebb, Harry C. Hull, and George A. Stewart. Dr. Pierpont's group conducted a thorough investigation of the surgical activities of the hospital, and then received permission of the Board of Trustees to turn their function over to the Baltimore City Medical Society. Dr. John M. T. Finney, Jr., President of the Medical Society at that time, appointed a committee headed by Dr. Edward S. Stafford to continue the survey and broaden its scope, so as to include all aspects of the hospital organization. The committee included representatives of the various specialties as well as Dr. Edwin L. Crosby, then Medical Director of the Johns Hopkins Hospital. At the conclusion of the official survey by the Medical Society, the recommendations made by Dr. Stafford's committee were submitted to the hospital trustees, who agreed to put into effect the plan of reorganization of both the administrative and medical staffs. The first measure taken was the appointment of Mr. David B. Snyder as Administrator in May 1951. Another recommendation carried out was the creation of a Medical Advisory Board composed of recognized surgeons, specialists, and other physicians to direct the medical policies of the hospital. Dr. Henry J. Wollenweber served as the first chairman of this board, and was succeeded in March 1952 by the writer. At the same time the trustees appointed one of its members, Mr. Max Sokol, a member of the Baltimore bar, chairman of a committee to negotiate with the Baltimore City Medical Society in an effort toward early approval of the hospital by the A.M.A. A joint group of the trustees and the medical board of the hospital held a series of meetings with the officers and Executive Committee of the Medical Society, with Dr. Samuel McLanahan, Jr. presiding. In October 1952, the Medical Society put its approval on the measures taken by the trustees to reorganize the hospital, and forwarded to the American Medical Association its recommendation that Doctors Hospital be approved. Early in December, official notification from the Chicago headquarters of the A.M.A. was received by the hospital.

The Medical Advisory Board is made up as follows:

William Schuman, *Chairman*
Surgery—Ross Z. Pierpont
Edgar F. Berman
Donald B. Hebb
Benjamin Sarubin (chief)
Medicine—A. A. Sussman (chief)
Stephen J. Van Lill 3rd
Pediatrics—C. Loring Joslin
Neuropsychiatry—Leon Freedom
Pathology—Henry J. Wollenweber (Pathologist)
Obstetrics and Gynecology
Christian F. Richter
Earle M. Wilder
William Schuman (chief)
Orthopedics—I. H. Maseritz
Milton J. Wilder
Urology—Charles Levy
Ear, Nose, & Throat—Jerome Snyder
X-ray—Eugene L. Flippen (Radiologist)

In addition to the Medical Advisory Board, there is an Executive Committee, which is the working committee of the staff,—including such functions as credentials, records, house staff, clinical conferences, tissue review, etc. This committee is composed of the department chiefs and an equal number of general practitioners. Decisions of the Executive Committee are subject to the approval of the Medical Advisory Board. The original visiting staff of 50 doctors has increased to 125 general practitioners and specialists. The hospital has a qualified Resident and two internes. A unique feature of the hospital is a formally organized Institute of Postgraduate Medical Studies for general practitioners, the courses of which are approved for credit by the Maryland Chapter of the American Academy of General Practice.

Doctors Hospital is a member of the American Hospital Association and is affiliated with the Maryland Hospital Service (Blue Cross). It has 85 beds, of which 18 are obstetrical and 15 pediatric, the remainder being for acute medical and surgical cases. The hospital has a ward service for obstetrical patients, and conducts a pre-natal clinic. Plans for future expansion include two additional floors to double its present capacity, an accident and outpatient department, and improved facilities in all existing services.

The role taken by the Medical Society in assuming the function of an investigator for the A.M.A. is probably unprecedented locally. That it performed this function with great efficiency and guided by the best traditions of the Society is acknowledged by all concerned. It will be of future interest whether this will remain an isolated experience for the medical Society or that other instances will arise in which the Society will be called upon to act as an investigating and recommending body in the organization of a local hospital. The fact remains that in the case of Doctors Hospital the result was most salutary for the hospital, the medical profession, and the entire community.

The writer, on behalf of the Board of Trustees and the Medical Advisory Board of the hospital, desires to take this opportunity to express their appreciation and admiration for the constructive efforts made by the original voluntary survey group and by the various officers and survey committee members of the Medical Society to bring Doctors Hospital to its present state of organization. Particularly noteworthy has been the splendid spirit of cooperation shown by Dr. McLanahan, recent President, and Dr. Wetherbee Fort, present President of the Society. Acknowledgment is also made to Dr. George H. Yeager, Editor, for space in this Journal to tell the story of the reorganization and approval of the hospital.

With the Medical Society promising to maintain a continued interest in the progress of Doctors Hospital, it is the determination of the hospital trustees, medical board, and staff to pursue every means for the further improvement of the hospital, so that general practitioners and specialists of every segment of the local profession will proudly associate themselves with Baltimore's youngest hospital.

FAMILY SPENDING FOR MEDICAL CARE

THE AMA WASHINGTON LETTER NO. 9, FEBRUARY 27, 1953

Government statisticians estimate that the average urban family spent 4.7% of all its expenditures on *medical care* in 1952. The Bureau of Labor Statistics, which computes the monthly cost of living index, has divided total family spending as follows: 30.1% for food, 32.0 for housing, 9.7 for clothing, 11.0 for transportation, 4.7 for medical care (including health insurance costs), 2.1 for personal care, 5.5 for reading material and television and 5.0 for other goods and services. In arriving at price changes in family spending each month, BLS will take into account price fluctuations in each category listed above. The revised index is the outgrowth of a study that started in 1950.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. GEORGE H. YEAGER, *Auxiliary Editor*

REVIVING AN OLD TRADITION

Records at the Medical and Chirurgical Faculty Building bear evidence that "in the good old days" early in 1900 there were many parties and various entertainments to which the doctors brought their wives. Therefore, the Auxiliary feels that this year in sponsoring The Medical and Chirurgical Ball on the Monday night that the Annual Meeting opens, by holding the Joint Faculty-Auxiliary Luncheon, on Wednesday, to hear Dr. Bauer, President of the A.M.A. speak, and by again putting on the annual Creative Arts Show, we are actually only reviving or renewing that old "College" spirit!

The Faculty Ball is not really a new idea either, but is a good one, a way to get us all to town in plenty of time for the Annual Meeting. It will provide us with a chance for a state wide reunion in a relaxed atmosphere and in pleasant surroundings. It gives Baltimore City, at last, an opportunity to at least start to return in kind some of the gracious hospitality always extended by the Counties at the Semiannual.

Be sure to make *hotel reservations* early for Monday night, April 27th. Pack that black tie or dark suit, and gay gown and meet us at "The Alcazar" for *An Evening In Paris!*

Mrs. E. Ellsworth Cook is General Chairman of The Medical and Chirurgical Faculty Ball; Mrs. Ross C. Brooks is Chairman on Arrangements; Mrs. Irving Taylor, Folies "Bare" Gère; Mrs. Richard Garrett, Tickets; Mrs. Arthur T. Ward, Jr., Co-Chairman, Tickets; Mrs. John DeHoff, Program; Mrs. J. Arthur York; Patron List; Co-Chairmen on Patrons are Mrs. Homer Todd and Mrs. Everett S. Diggs; Mrs. Edwin Stewart, Public Relations and Mrs. Newland E. Day, Reservations; Mrs. Norman Freeman is Co-Chairman on Reservations. Mrs. Raymond Markley has Decorations; Mrs. Harold Vyner, Recruitment Dolls; Mrs. Thomas C. Webster, Novelties; Mrs. Philip Lerner, candy; Mrs. W. Kennedy Waller, Perfume from Helen Dugan Boyce, Inc.; Mrs. Daniel Pessagno, Flower Girls; Mrs. James Russo, Co-Chairman, Flower Girls; Mrs. Joseph C. Sheehan, French Fashions; Mrs. Robert Goldstein, Singing Star; Dr. Louis Kolodner, Master of Ceremonies; Mrs. John R. Davis, Mrs. Hyman Schiff, and Mrs. Jack Rosin, Telephone Chairmen; and Mrs. J. C. Wich and Mrs. Herbert Wilgis, Publicity.

Mrs. Beverley C. Compton is Chairman of the Creative Arts Show; her Co-Chairmen are Mrs. Frank R. Smith, Jr., and Mrs. Everett S. Diggs. Art Chairmen are Mrs. John Parsons and Mrs. A. Murray Fisher. Other Committee members are: Mrs. I. Ridgeway Trimble, II, Mrs. Benjamin Rutledge, Mrs. Marius P. Johnson, Mrs. Howard C. Smith and Mrs. Thomas Chambers. County representatives are: Mrs. Louis Z. Dalmau, Mrs. A. Talbot Brice, Mrs. P. S. Lansdale, Mrs. J. M. Bankhead, Mrs. David S. Clayman and Mrs. S. R. Wells.

AMERICAN MEDICAL EDUCATION FOUNDATION

One of the A.M.A.'s goals for 1953 is to *explain* as well as to actually extend Medical Education and the doctor supply to the public. "Today's Health" has been listed as one of the media to be used in this educational project, and a great effort is under way to make this only factual, authentic, health magazine also the most attractive and appealing one on the market. Another medium to be used in connection with the A.M.E.F. educational appeal is the film "Your Doctor" 16 m.m. available free from A.M.A. film library, 535 North Dearborn Street, Chicago 10, Illinois. If your own local Auxiliary has not yet joined in support of the A.M.E.F. please remember the plea of our National Auxiliary Committee on the subject, which is "Every Auxiliary a Contributor!" After all, under an Administration that is declared to be friendly to *every* kind of American effort, responsibility, and initiative, we have a chance to show that private sources can and will come to the aid of our Medical Schools without government interference.

KNOW THE ANSWERS!

As a doctor's wife you will be better informed if you've read two new pamphlets available free from the A.M.A., P. R. Department, 535 North Dearborn Street, Chicago 10, Illinois. They are: "I. L. O. Spells Danger" (International Health Organization) and "How To Pay Your Medical Bill." In addition, there is a small inexpensive book that will make you think, called "Remember These Things" by Paul Harvey and available from The Heritage Foundation, 75 East Wacker Drive, Chicago 1, Illinois.

TABLES RESERVED FREE

While they last, tables may be reserved, without charge, for the Medical and Chirurgical Faculty Ball, to be held on Monday night, April 27th, at "The Alcazar" in Baltimore, as part of the Annual Meeting Program. Members of the Faculty or the Auxiliary may engage a table for ten simply by writing or telephoning Mrs. Newland E. Day, 3424 Guilford Terrace, Baltimore 18, Maryland. Telephone—HOpkins 2977.

VOLUNTEER YOURSELF!

General Williams, Medical Director of Civil Defense, who recently spoke to the Woman's Auxiliary to the Baltimore City Medical Society, mentioned the need for women who will take the Nurse Assistant, Nurse's Aide or First Aid courses, and the need for each neighborhood or city block to organize a baby-sitting center so that active mothers may be released to man Casualty Clearing Stations or to assist Hospital or other Civil Defense posts. However, General Williams cautioned that "the best way to get out volunteers is to *first* volunteer yourself! Americans like to lead, but resent being pushed."

SAFETY CAMPAIGN MOVIE

Our Maryland Auxiliary has been particularly concerned over the automobile accident toll. Most accident prevention weeks, home, school, rural, etc., are sponsored on a local level. There is usually a local Safety Council which will welcome any Auxiliary support. If you want to use a very clever animated cartoon to enliven a "safety" program there is one called "Once Upon a Time" available from the Metropolitan Life Insurance Company, 1 Madison Avenue, New York 10. This may also be used on Television.

ARMED FORCES TO REDUCE CALL ON DOCTORS, PRESIDENT ANNOUNCES

THE AMA WASHINGTON LETTER NO. 9, FEBRUARY 27, 1953

After first planning to call up *1,800* physicians for April, May and June, the military services have decided they can get along with *1,200*. Announcement of the lowered quota was made by President Eisenhower, who credited the reduction to recommendations of the Rusk Committee. The 1,200 to be taken in the next quarter compare with *1,552* called up in January, February and March.

Meanwhile, Defense Department's bill for extending the doctor draft act, made public two weeks ago, still has not been introduced on Capitol Hill. It is known that Office of Defense Mobilization and the Budget Bureau are giving it careful study. Also, there are reports that White House advisers are hopeful that more reforms can be written into the bill.

MEDICAL SECTION

of the

BALTIMORE CITY MEDICAL SOCIETY

1211 Cathedral Street

Tuesday, May 12, 1953, 8:00 p.m.

Election of Officers.

Important message.

This will be a brief meeting. This is the first time this Section has held a meeting and all the members are urged to attend.

SYMPOSIUM ON USE AND ABUSE OF DRUGS AND COSMETICS

Osler Hall, 1211 Cathedral Street, Baltimore

Friday, May 15, 1953, 8:00 p.m.

Participants:

Dr. Kenneth C. Blanchard, The Johns Hopkins Hospital, *Moderator*
Dr. Milton S. Sacks, University Hospital
Dr. Leslie N. Gay, Baltimore
Mr. Paul C. Wolman, Jr., Assistant United States Attorney, Baltimore

The Symposium is under the auspices of the Joint Committee on Medicolegal Problems of the Baltimore City and Maryland Bar Associations and the Medical and Chirurgical Faculty. The program is being arranged by the Symposia Management Subcommittee which is composed of the following members: Mr. S. C. Berenholtz, Mr. W. L. Galvin, Mr. A. Sodaro, Mr. T. C. Waters, Dr. R. S. Fisher, Dr. L. Krause, Dr. R. C. Tilghman, and Dr. I. R. Trimble.

All the members of the Medical and Chirurgical Faculty are cordially invited to attend this meeting.

ANESTHESIOLOGY SECTION

of the

BALTIMORE CITY MEDICAL SOCIETY

1211 Cathedral Street

Edward I. Lederman, M.D., *Chairman*   Leah R. Camp, M.D., *Secretary-Treasurer*

Wednesday, May 20, 1953, 8:30 p.m.

Contributions of an Anesthesia Study Commission. Henry S. Ruth, M.D., Professor of Anesthesiology, Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania.

Maryland STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 2 *May, 1953* NUMBER 5

EDITORIAL

GYNECOLOGY IN GENERAL PRACTICE

EMIL NOVAK, M.D.*

A large proportion, probably a majority, of the patients of every general practitioner is made up of women. A considerable segment of this female practice has to deal with the diagnosis and management of gynecologic disorders of one sort or another. Some of these are actually of minor nature, though the proper interpretation and management of even these simpler problems is scarcely possible without a careful history, a conscientiously thorough examination, and the reasonable degree of gynecologic knowledge which nowadays can be expected from a good general practitioner.

The general practice of medicine is coming into its own again, and no one should welcome its renaissance more warmly than the specialists. The relatively young American Academy of General Practice is doing a good job in encouraging the development of a well-rounded type of general practitioner, and its fine monthly publication, G.P. is a powerful medium in this crusade. It is not surprising that an increasing proportion of our young medical graduates are seeking internships which offer training in this higher type of general practice, especially since the economic and military stress and uncertainty of the present day is likely to discourage these young men from spending the four or five years of postgraduate training necessary for specialist qualification. More and more hospitals are establishing approved general practice internships, and more and more of them are creating staff sections of general practice, and the powerful influence of the A.M.A. has been brought to bear in furthering this movement.

I mention these things because I believe that the better type of general practitioner is well equipped to handle many minor gynecologic problems, not only because he has had the initiative to learn a good deal about them, but also because he knows enough to know his own limitations. He wouldn't think, for example, of treating abnormal bleeding in a middle-aged or old woman without making the pelvic examination which he has qualified himself to make properly, and he certainly wouldn't give her hormones before he makes such an examination, as some of his less progressive and less conscientious colleagues still do.

Speaking of hormones, he certainly wouldn't reach for his hypodermic and begin to give "shots" to every woman over forty just because she complains of nervousness, headaches and irritability, though she is menstruating perfectly normally and has none of the vasomotor flushes and sweats which are the symptomatic criteria of the menopause. He will know that such vasomotor symptoms rarely occur while the woman's ovaries are still functioning and supplying her with all the estrogen she needs, and that the vague functional symptoms of so many middle-aged but normally menstruating women have nothing at all to do with the menopause, which may not occur until many years later. He will take the time to convince himself that such a woman has developed these symptoms because of domestic, economic or marital stresses of one sort or another, such as the worries of rearing a large family of children or contending with an unsympathetic or misbehaving husband. He will have made himself a pretty good amateur psychiatrist, and he will have learned that the term psychosomatic medicine is more than a mere cliché or a new fad, and that it refers to the kind of medicine which all doctors with common sense and a good conscience have always practiced.

---

* Member of the Editorial Board, Maryland State Medical Journal.

The right type of general practitioner will also know that the menopause, when it comes, is not a disease but a perfectly normal phase of a woman's life, and he should take the time and trouble to explain to apprehensive women what the menopause is and especially what it isn't, that it never causes insanity, that it does not mean the end of normal sex life, and that a woman is not doomed to becoming gross and fat. Above all he will impress on her that most women need no hormones of any kind and are better off without them, which may surprise her because so many of her friends have been taking "shots" for years.

But our sensible and well-informed doctor will patiently explain that the menopause is merely a transition phase during which the cessation of ovarian function imposes on endocrine readjustment which is usually manifested by vasomotor symptoms such as flushes and sweats, but that such symptoms are ordinarily easily tolerable, that they disappear in a reasonable though unpredictable time and that it is better to get along without hormones if possible. He knows, of course, that in a small proportion of women the symptoms are so severe that they are entitled to the relief which interrupted estrogen therapy can give, but he will impress on the patient why continuous estrogen therapy is both irrational and hazardous.

He wouldn't think, for example, of giving a woman a prescription for stilbestrol or any other estrogen without emphasizing that the substance be taken only when and if the symptoms are really severe, because he knows that continuous dosage means putting into the woman's body something that nature is trying to get rid of, thus putting off the inevitable and necessary pituitary-ovarian readjustment and prolonging the duration of the menopause, and he will surely warn the woman that too long estrogen therapy frequently causes postmenopausal bleeding which worries both the patient and the doctor. For that matter, he is justified in telling her that there is good reason to believe that such excessive estrogen therapy may sometimes actually predispose to the development of endometrial cancer. If I were sitting by admiringly as the doctor thus talked to his patient, I could chip in by telling of many instances of such harmful estrogen therapy, including one in which a patient had been taking a 1 mg. tablet of stilbestrol nightly for twelve years.

If estrogen therapy for menopausal symptoms is necessary, our model young doctor would certainly give this orally and not hypodermically, not only because the oral plan is just as effective, more convenient and agreeable, and cheaper, but because of the danger of a psychologic "shot" addiction which is extremely hard to break. I would feel proud if he quoted me as saying that I have not used "shots" for this purpose for many years, and I am sure that many of my colleagues can say the same. For that matter, I suspect that our fine young colleague, with his high ideals of medical practice, would be sensitive about using shots because he might be accused of carrying on a profitable racket, keeping his patients trotting back and forth for innumerable shots at so much per.

I have felt justified in elaborating on this particular aspect of office gynecology simply because I believe this to be one of the most glaring and widely prevalent therapeutic abuses in our profession, although endocrine therapy is often also used very unintelligently for many other supposed indications, especially menstrual disorders of one sort or another and sterility. It is not possible, within the limits of a comparatively short editorial, to discuss these in any detail. Suffice it to say that rational endocrine therapy presupposes at least some familiarity with the normal reproductive hormonal mechanism, and its possible aberrations, and that it is really not difficult to acquire at least an elementary but adequate knowledge on these matters either from textbooks on endocrinology or from the chapters on this subject in any good textbook of gynecology.

Any type of gynecologic disease is apt to be encountered in the office of the general practitioner. Leucorrhea is certainly one of the most if not the most common, and the well-equipped doctor will not be satisfied simply to prescribe douches, but will make an effort to get at the cause, whether this be a chronic cervicitis, a trichomonas vaginitis, or what not. As with pain and bleeding, no intelligent evaluation or treatment is possible without pelvic examination. Backache, again, makes many women decide they have trouble with the pelvic organs or kidneys, but it is far more likely to be due to trouble with the back itself than to either of the above factors. How far the general practitioner will himself wish to go in the matter of diagnostic and therapeutic implications must depend on his own training, predilections and conscience. There are of course some who are well qualified to carry out such procedures as cervical cauterization, biopsy and tubal insufflations themselves, while perhaps the majority will prefer to transfer the complete responsibility to a gynecologist. "Dat old debil," conscience, must frequently be a final arbiter in this respect.

I have left for the last what I believe is the general practitioners' greatest responsibility in the gynecologic field, his responsibility in the detection of pelvic cancer. The intensive campaign of popular education carried out in recent years by such organizations as the American Cancer Society has undoubtedly increased the proportion of cancer cases brought to light at an early and relatively favorable stage and it is strongly endorsed by the medical profession. But are the profession's own skirts clean, and aren't there still a good many cases in which a deadly delay in diagnosis is clearly chargeable to the doctor and not the patient? There certainly are, as shown by the statistical analysis of a large number of fully investigated cases by the Philadelphia Committee on Pelvic Malignancy. Undue and sometimes very long delay on the part of the doctor was established in no less than 28 per cent of the cases. A similar committee of the Medical and Chirurgical Faculty is now in the second year of its work, but already it is evident that its findings will be pretty much like those of the Philadelphia group.

The first port of call of most cancer patients is to the general practitioner, and it is obvious that it is he who often determines the fate of the patient. Often enough she may already be in an advanced stage of the disease when she consults her family doctor, but in other cases the disease is in an early or covert stage, but needing only the intelligence, alertness and conscientiousness of her doctor to bring it to the surface. The advanced stages can be diagnosed all too easily by anyone who makes the simplest pelvic examination, but the very early phases often call for such diagnostic procedures as biopsy and vaginal smear studies. Both of these require special training, and I rather think that the great majority of practitioners will prefer to place this serious responsibility on the gynecologist. Even the latter, together with his pathologist confrére, will at times have to do some sweating to arrive at a correct diagnosis. The late Dr. Joseph C. Bloodgood used to like to say that the easier the diagnosis the worse the prognosis, and in general this is undoubtedly true. On the other hand, the reward to the patient is apt to be great if both she and her physicians have to go to a lot of trouble to establish the diagnosis of early cancer.

This is not the place to detail any of these special diagnostic methods. Suffice it to say that, as so many have emphasized, every doctor's office should be a cancer detection clinic. He should, above all, impress upon all his women patients the fact, as I believe it to be, that the most important measure which the patient herself can take in protecting herself against cancer is to have a competent examination at intervals of about six months. If all women could have such examinations, at present a utopian dream, there is not the slightest doubt that the mortality figures of pelvic cancer would show a spectacular drop.

In conclusion, I have thought it best not to attempt a discussion of the many gynecologic diseases encountered by the general practitioner, for this would be almost like writing a condensed textbook of gynecology. I have thought it best to concentrate upon and emphasize two subjects, viz. (1) A warning against the widespread abuse of endocrine therapy, especially for menopausal symptoms, and (2) A plea for all practitioners to be constantly on the alert for the detection of pelvic cancer.

NATIONAL AUXILIARY CONVENTION

Wives of Faculty members are cordially invited to participate in the National Convention of The Woman's Auxiliary to the American Medical Association at the Hotel Statler, Tuesday, June 2nd through Thursday, June 4th. The Maryland Auxiliary hopes for a big representation this year since so many Faculty members will be in New York for A. M. A. meetings and their wives will be right there for the convention.

ARMY REVIEWING PHYSICAL RECORDS OF 1,000 PRIORITY 3 PHYSICIANS

The AMA Washington Letter, No. 4, January 23, 1953

The Army Surgeon General has asked area surgeons in the U. S. to review records of about 1,000 priority 3 physicians who were deferred for physical reasons prior to lowering of physical standards. A number of doctors in this group are expected to be found fit for duty. Under lowered standards announced last month, each case is decided on its own merits. Generally, the armed services are taking the position that if a doctor is physically able to carry on a private practice then he is fit for military service.

Since the Defense Department announcement on lowered standards, the Army has sent to Selective Service for re-evaluation the names of 739 deferred physicians in priorities 1 and 2. Of this group, 487 have received physical examinations.

Dr. Daniels Dr. Tilghman Dr. Stone

DR. HARVEY B. STONE

Congratulations to The Johns Hopkins Hospital Medical and Surgical Association, and best wishes to Dr. Harvey B. Stone for a successful tenure of office as its President.

Dr. Stone has been a leader of the Medical and Chirurgical Faculty of the State of Maryland for many years. He was its President in 1941, and served on the Council for 25 years, being the Chairman from 1942 to 1946. He has been outstanding in his generosity and willingness to render service to the Medical and Chirurgical Faculty as well as the entire medical profession.

In addition to the many honors which have been extended to him, Dr. Stone is a Past President of the American Surgical Association, and the Southern Surgical Association. He is now a member of the Council on Medical Education and Hospitals of the American Medical Association.

The photograph, which is reproduced through the courtesy of the Sunday American, March 1, 1953, shows Dr. Stone, newly elected President of The Johns Hopkins Hospital Medical and Surgical Association, being congratulated by the Past President of the Organization, Dr. Worth B. Daniels, Professor of Medicine at Georgetown University, and Dr. R. Carmichael Tilghman, the Secretary-Treasurer of the Association.

Scientific Papers

THE SURGICAL APPROACH IN THE TREATMENT OF PULMONARY TUBERCULOSIS[1, 2]

OTTO C. BRANTIGAN, M.D.

To simplify a discussion of the surgical treatment of pulmonary tuberculosis one must separate the surgical treatment of uncomplicated pulmonary tuberculosis from the surgical treatment of pulmonary tuberculosis complicated by empyema, bronchopleural fistula, chest wall infection and conditions following other surgical maneuvers.

The treatment of pulmonary tuberculosis can be outlined clearly and briefly. Since it is a bacterial disease its elimination by prophylactic measures should be possible. In this country the greatest effort was put into the elimination of contacts and the program has been highly successful. The use of B. C. G. in this country has been added in the past few years. Where prophylaxis has failed medical treatment becomes necessary. Only a few years ago the treatment of pulmonary tuberculosis consisted of rest, diet and symptomatic relief; it now includes effective antituberculous drugs and the ability to keep down secondary infection with potent antibacterial drugs. The vast majority of people who develop pulmonary tuberculosis recover from the disease by medical measures alone. When medical measures fail to cure the disease or when the progress of medical treatment is delayed surgical treatment is employed. Surgical treatment is an adjunct to medical therapy. The better the medical therapy before and after surgery the more satisfactory will be the end results of surgery, regardless of the type of surgery used. Surgical therapy can be classified as excision, collapse measures, and cavitary drainage.

As medical therapy improves and becomes more effective there will be a change in the indications for surgery. Surgical procedures once employed to help the patient over an acute phase of the disease are no longer used since the antituberculous drugs produce better results, and are easier and safer for the patient. A perusal of Chart No. 1 will indicate the changes that have been effected in the various types of operations that have been applied to the patients with pulmonary tuberculosis. The geographic location which might influence the type of disease, the source of patients and the doctors making the decisions have remained essentially the same over this period of time. It is obvious that the change in the surgery applied has been noted in the group where the disease was not too extensive. In the era before streptomycin there was not enough disease to warrant thoracoplasty; therefore, pneumothorax was carried out as indicated by pneumonolysis. The frequency of pneumothorax and pneumonolysis was reduced when lucite ball plombage was introduced, and finally as the percentage of pulmonary resections has increased there has been a further reduction in pneumothorax with pneumonolysis and in temporary phrenic paralysis. It is interesting to note that the percentage of thoracoplasties has remained fairly constant during these years. So far as can be determined there has been no change in the indications for thoracoplasty. There has, of course, been a definite increase in the application of pulmonary resection.

---

[1] Presented before the Joint Staff Meeting of Franklin Square, Maryland General, South Baltimore General and Lutheran Hospitals in Osler Hall, Medical and Chirurgical Faculty Building, Baltimore, on January 27, 1953.

[2] From the Department of Surgery, School of Medicine, University of Maryland and Baltimore City Hospitals.

Careful consideration and accepted surgical indications at the present time may be changed completely by the discovery of a more potent antituberculous drug. The time may come when surgery will be used only to correct structural deformities created by the disease such as bronchiectasis, bronchial stricture, and other anatomic deformities.

Effective medical therapy is creating a decided change in the pathologic symptomatology found in tuberculosis. Formerly there were many stages of the pathologic process in a single lobe of the lung, such as ulceration, exudation, caseation, and fibrosis. The type of surgical treatment heretofore employed either embraced all the pathologic processes or it considered only the one thought to be most dangerous to the patient. Improved medical therapy is producing more generally a single pathologic process. The common pathologic lesion after medical treatment consists of a small persistent cavity, a fibrotic area, atelectasis of a lobe or part of a lobe, or a localized solid lesion (tuberculoma-like). These lesions represent two distinct aspects of the disease: one, where there was extensive disease and medical therapy eliminated all but the persistent lesion, and the other where medical therapy has perhaps confined the lesion to an isolated persistent one. From a study of these lesions it is possible that in the future the dangerous initial lesion can be recognized. The type of surgical treatment most applicable for these single isolated lesions appears to be local excision or segmental resection.

CHART 1

Operations for Pulmonary Tuberculosis

OPERATION	NO STREPTOMYCIN 1944 & 1945		WITH STREPTOMYCIN					
			1947 & 1948		1949 & 1950		1951 to Aug. 1952	
	No.	%	No.	%	No.	%	No.	%
Thoracoplasty	94	30.3	158	26.6	99	28.1	59	28.7
Pulmonary Resection	7	2.2	41	6.9	29	8.2	46	22.4
Phrenic Crush	57	18.3	136	22.9	75	21.3	18	8.7
Closed Pneumonolysis	143	46.1	153	25.8	46	13.1	19	9.2
Lucite Ball Plombage	0		72	12.1	80	22.7	51	24.8
Lucite Ball Prosthesis	0		19	3.2	8	2.2	3	1.4
Open Pneumonolysis	8	2.5	2	0.3	0		0	
Monaldi	0		8	1.3	14	3.9	6	2.9
Miscellaneous	1	0.3	3	0.5	1	0.28	3	1.4
Total	310		592		352		205	

Improved medical therapy and its resultant single pathologic lesion create a serious problem in recognizing the healed lesion. In spite of a persistent negative sputum the small open cavity must be considered a potentially active lesion and it should be subjected to surgical treatment. Even before the knowledge and use of chemotherapy it was thought by some workers (2, 29, 30) that tuberculosis might heal by epithelization of the cavity. With effective chemotherapy to sterilize the cavity it would appear that collapse and obliteration of the persistent cavity will be necessary to prevent the ingrowth of bronchial epithelium from lining the cavity. The persistent small solid or fibrotic lesion with a negative sputum may represent healed disease and surgery may be unnecessary. It should be remembered that for years many workers (2, 24, 29, 30) thought the most frequently occurring method of cavitary healing was closure of the bronchial opening and cavity filling with inspissated material that would be gradually absorbed. Medlar (25) reported, however, that the bronchi leading to such lesions never close by scar tissue and Shields (33) believed that they remain as dangerous foci. On the other hand, Gordon (18) has shown the absence of tubercle bacilli in surgically resected necrotic lesions previously treated by antituberculous drugs.

Since the surgeon is confronted by the patient who has a persistent lesion in spite of good medical therapy or the patient whose progress has not been satisfactory under good medical therapy, he must, with the aid of his medical colleagues, apply the surgical method best suited to the particular patient. He can choose resection, collapse therapy, or cavity drainage.

The type of surgical procedure selected is determined by a number of factors: (a) the age and condition of the patient; (b) the type and extent of the pulmonary lesion; (c) the resulting cardiorespiratory functional impairment occurring with the particular operation; (d) the morbidity, mortality and cure rate of the particular operation. The more simple these factors can be made, the easier will be the decision.

In considering the age and condition of the patient it is fortunate that many patients are young, in good physical condition and without concomitant disease. In the presence of diabetes it is thought that excision of the lesion is most desirable when the extent of the lesion and the condition of the patient will permit. Where there is definite respiratory impairment before surgery it may be necessary to use extrapleural pneumothorax or plombage.

When the extent and type of pulmonary lesion are considered many facts seem evident. So far as the extent is concerned, there is a limit to the amount of lung tissue that can be excised and bilateral excision is fraught with more dangers than unilateral excision. Collapse (especially pneumoperitoneum) therapy (4, 23) can be applied to extensive disease whether unilateral or bilateral. If the extent of the disease is minimal or an isolated single lesion is present excision surely seems the procedure of choice since little lung tissue is destroyed and no secondary procedure need be followed to prevent overdistention of the remaining lung tissue. When a whole lung is involved and the opposite lung is free of disease excision is the only reasonable procedure. For bilateral lesions and for those that are more than minimal or less than the whole lung in extent excision must be carefully weighed with the other surgical procedures available.

A careful study of the type of lesion has revealed that certain lesions are not suitable for collapse treatment. These are (a) solid type lesions; and (b) lesions resulting from major bronchial disease which cause giant cavities, tension cavities, atelectasis, fibrotic bronchial stricture, bronchiectasis and the so-called destroyed lung. These lesions should be resected if the extent of the disease and the condition of the patient will permit. Other types of lesions may indicate collapse therapy or excision, depending upon the thoughts and desires of the physicians and their patients.

In considering the extent of the pulmonary lesion it should be remembered that collapse measures may be applied when the extent of the lesion precluded excision, even though it is not the type of lesion suitable for collapse. Cavitary drainage may be applied for the same reasons.

When analyzing the impairment of cardiorespiratory function after operation it is important to realize the effect of various surgical procedures. Even though the temporary collapse measures may on occasion become permanent, it should be realized that phrenic paralysis, pneumothorax and pneumoperitoneum may be beneficial in the treatment of certain types of pulmonary tuberculosis and may result in little or no permanent functional impairment. In the so-called temporary phrenic paralysis operation the undesirable permanent paralysis of the phrenic occurred in one-fifth of the 335 operations reported by Seiler (34), in 10 per cent reported by Pinner (31), and in 5 per cent of 546 patients reported by Crow (11). Hardy (19) reported a series of temporary phrenic paralysis combined with pneumoperitoneum which occurred two years or more after operation. He reported

15 per cent of 143 patients who had permanent reduction of function of the diaphragm after the first operation and 24 per cent of 49 patients who showed permanent reduction after the second operation. Care in the method of surgical technic and in the type of disease treated by temporary phrenic paralysis, pneumothorax and pneumoperitoneum will materially reduce the permanent functional impairments experienced in these procedures. The localized pulmonary excision undoubtedly rivals these temporary methods of collapse therapy so far as permanent functional impairment is concerned. Gaensler (14, 15), Dressler (13), and Gaubatz (17) have shown less functional impairment after extrapleural plombage than after any other method of collapse or resection therapy. Gaensler (14, 15) and others have reported that the standard thoracoplasty probably impairs pulmonary function about as much as pneumonectomy or lobectomy and, interestingly enough, there is little difference in pulmonary function between lobectomy and pneumonectomy when measured by vital capacity and maximum breathing capacity. It, however, is obvious that the patient has more pulmonary reserve following thoracoplasty or lobectomy than after pneumonectomy.

In considering the morbidity, mortality and cure rate of the various operations that may be applied to the patient with pulmonary tuberculosis it is difficult to arrive at definite conclusions. There are too many variable factors to arrive accurately at statistical data from the literature. The age and condition of the patient, the type and extent of the lesion, the type and duration of medical therapy, and the time interval followed after surgery all influence the morbidity, mortality and the end result of surgery. It is now important to distinguish, especially in pulmonary resections, the era before and after streptomycin was available. Soon distinction will become necessary concerning the use of other antituberculous drugs or combinations of drugs. Charts No. 2 and 3 represent material gathered from the recent literature. (Certain interpretations had to be made in order to place the figures in a chart. The author begs forgiveness if the interpretations are not as intended by the original authors.) It was possible to separate pulmonary resections reported before the era of streptomycin and after streptomycin became available. Accordingly, pulmonary resections in the streptomycin era were used. This distinction could not be made in the reports on thoracoplasty. The charts are rather incomplete but they show an overall operative mortality of 6.7 per cent for all types of pulmonary resections against 4.8 per cent for thoracoplasty. The cure rate for pulmonary resections is 75.8 per cent against 56.7 per cent for thoracoplasty. Because of the variable factors including the age, condition of patient, extent of lesion, type of medical therapy and duration followed after surgery, these figures represent only the trends in mortality and the cure rate. It is obvious that the present day operative mortality rate is far less in thoracoplasty and that the operative mortality for segmental resection or local excision of isolated pulmonary lesions is small when compared to lobectomy or pneumonectomy. Of course, if only a single segment or localized area is resected there is little or no disturbance of physiology or pulmonary function so long as pleural and other complications are avoided. After segmental resection no procedure need be supplemented to reduce pleural volume and therefore mortality should be much lower than in lobectomy or pneumonectomy. It is evident that pulmonary resections should not be considered as a group. Careful distinction should be made between pneumonectomy, lobectomy or segmental resection. However, it must be clearly understood that when a patient is being considered for resection surgery, pulmonary resection implies the removal of all the disease regardless of the extent of the resection that may be necessary. Obviously each surgeon or group of physicians treating pulmonary tuberculosis should know their own results of various types of surgery and be guided accordingly. The results of the work of

CHART 2

Resection in Treatment of Pulmonary Tuberculosis

(Streptomycin Era Only)

AUTHOR	DATE	FOL-LOWED	PNEUMONECTOMY					LOBECTOMY					SEGMENTAL					ALL RESECTIONS				
			No.	Well	Sick	Dead		No.	Well	Sick	Dead		No.	Well	Sick	Dead		No.	Well	Sick	Dead	
						Op.	Tot.				Op.	Tot.				Op.	Tot.				Op.	Tot.
		yrs.																				
Gale (16)	1949	1–3	47	82.9	10.6	2.5	6.3	33	84.8	9.0	3.5	6.0						80	83.7	10.0	2.5	6.2
Bailey (3)	1949		69			15.9		25			20.0		6			0.0		100	77.0	2.0	16.0	16.0
Sweet (37)	1950		36	38.9	8.3	19.4	52.8	27	44.4	22.2	7.4	33.3						63	41.3	14.3	14.3	44.4
Chamberlain (10)	1950	2½											75	86.7		1.3	2.4	75	86.7		1.3	2.4
Day (12)	1950	1–4	104	55.7	25.9		18.0	98	63.2	30.6		6.1						200	59.4	28.2	6.9	12.4
Brantigan (6)	1950	1–3	27	77.7	18.5	0.0	3.7	2	100.0	0.0		0.0						29	79.3	17.2	0.0	3.4
Meyers (26)	1951	1–5	36	66.6	8.0	2.7	25.0											36	66.6	8.0	2.7	25.0
Sive (35)	1952	1–4	56	63.0	8.9	3.5	16.0	28										84	64.2	25.0	2.4	10.7
Overholt (28)	1952	1–3	137	80.0	10.0		10.0	47	85.0	13.0		2.0	24	87.5	8.0		4.0	208	81.7	10.5		7.6
Total			512					260					105					877				
Total Well			300	67.9				151	72.9				86	86.8				626	75.8			
Total Op. Dead			22			8.1		8			9.2		1			0.9		45			6.7	

CHART 3

Thoracoplasty in the Treatment of Pulmonary Tuberculosis

AUTHOR	DATE	TIME FOLLOWED	NUMBER PATIENTS	WELL		NOT WELL		DEAD			
								Operative		Total	
				No.	%	No.	%	No.	%	No.	%
		yrs.									
Krynski (21)	1947	1–5	308	159	51.6	73	23.7	41	13.3	76	24.6
Rubin (32)	1949	2–6	168	89	63.1	32	22.7	9	5.3	20	14.2
Kinsella (20)	1949	5–26	613	306	49.9			34	5.5	203	33.1
Ottosen (27)	1951	1–9	130	98	75.2	6	49.9	(7)	5.5	16	19.9
Lees (22)	1951	5–15	278	174	62.5					75	26.9
Adie (1)	1952	1–17	334	194	58.0	48	14.3			104	31.1
Brantigan (7)	1952	1–8	82	66	80.4	6	7.3	1	1.2	6	7.3
Total			1913	1086	56.7	165	8.6	92	4.8	500	26.1

CHART 4

Operation for Pulmonary Tuberculosis

OPERATION	DATE	YEARS FOLLOWED	NUMBER PATIENTS	WELL	SICK	DEAD	
						Operative	Total
* Thoracoscopy and Closed (5) Intrapleural Pneumonolysis	1949	1–7	333	69.0	15.0	0.3	15.1
Lucite Ball Plombage (8)	1952	1–5	151	74.8	15.9	0.6	9.2
Resection (Streptomycin (6) Era)	1950	1–3	29	79.3	17.2	0	3.4
Thoracoplasty (7)	1952	1–10	82	80.4	7.3	1.2	7.3
† Resection (9)	1952		61			6.5	

* White patients only.

† Additional patients now being studied.

the author are shown in Chart No. 4. These figures apparently indicate the same cure rate regardless of the type of operation. The morbidity is practically the same for all procedures but the mortality rate varies.

In the report of 1950 the pulmonary resections done in the streptomycin era were a matter of chance as indicated by the additional 61 patients now being studied. The operative mortality of 6.5 per cent occurred mostly in the patients subjected to pneumonectomy. In patients who have had segmental resection or local excision of their lesion there has not as yet been a single fatality. This low figure will not persist as their numbers become greater. The figures do indicate, however, that when surgery is considered for an individual patient the operation best suited to the patient should be selected. The more extensive the operation the greater will be the mortality. Effort must be concentrated upon improving the cure rate. Undoubtedly the cure rate after surgery will improve as medical therapy becomes more effective.

It is difficult to give indications for the application of various operations in the treatment of pulmonary tuberculosis unless one is fitting the operation to a particular patient. As discussed above, there are many variable factors which influence the choice of operation. The individual may present factors that would justify more than one type of operative procedure.

Cavitary drainage can be either closed or open. In closed drainage it is generally applicable to the patient with a medium to large size cavity, where the extent of the disease or the condition of the patient prohibits resection or even a temporizing thoracoplasty. Closed drainage ordinarily is not a definitive procedure and in order to maintain cavity closure a thoracoplasty is needed. Often the patient who is not suitable for thoracoplasty improves sufficiently to become a thoracoplasty candidate after cavitary closure by closed drainage. The open drainage of a cavity is limited to the patient who has had a thoracoplasty and the cavity has remained open. This treatment is applied only when the patient is not a candidate for excision because of the extent of the pulmonary disease or when the condition of the patient will not permit a major operation. The cavitary drainage should be followed by a muscle transplant into the opened cavity as soon as infection is brought under control.

Collapse measures and their indication are difficult to discuss since there are so many different types that can be applied. However, collapse is contraindicated in (a) solid type lesions, and (b) lesions resulting from major bronchial disease which cause giant cavities, tension cavities, atelectasis, fibrotic bronchial stricture, bronchiectasis, and the so-called destroyed lung. Of the temporary types, pneumothorax and pneumoperitoneum rarely are placed before the surgeon for consideration and therefore will not be discussed.

Permanent phrenic paralysis probably has no place in the treatment of pulmonary tuberculosis. The temporary phrenic paralysis probably would be applied more frequently if permanent paralysis did not sometimes follow. If the operation were limited to a single hemostat clamping of the phrenic and accessory phrenic nerves permanent paralysis would rarely occur. Temporary phrenic paralysis is a measure probably used too infrequently. The only contraindication to this measure is that its application must not replace a better and more desirable surgical procedure. It is indicated (1) at the time of abandonment of pneumothorax; (2) as an adjunct to medical therapy when no other surgical procedure is contemplated; (3) as an adjunct to pneumoperitoneum, but in this situation permanent (36) paralysis is more likely to result.

The extrapleural plombage operation, whether air or other material is used for maintenance of collapse of the lung, should be applied only to those patients who have lesions suitable for collapse therapy and whose pulmonary lesion is no more than apical in extent. It is a simple operative procedure with a low mortality, low morbidity, and a high cure rate. It is a single operation, it is nondeforming, and it reduces pulmonary function less than any other major surgical procedure except localized excision of an isolated lung lesion. Extrapleural plombage should not be used in lesions where collapse therapy is contraindicated.

Thoracoplasty with its many modifications is difficult to discuss concisely and briefly. If the discussion is limited to the treatment of pulmonary tuberculosis and not applied to the complications of pulmonary tuberculosis nor to its application after pulmonary resection, then the problem of thoracoplasty is greatly simplified. In a patient whose condition permits major surgery the indications for thoracoplasty are (a) a lesion suitable for collapse therapy, where the extent of the lesion does not reach the base of the lung. (The author prefers lucite ball plombage for the apical lesion.) It is carefully considered before being applied bilaterally. (b) After closed cavitary drainage. (c) As a heroic measure in any type of tuberculosis where resection or other measures are contraindicated. Surprising results are sometimes obtained in this category.

The type of thoracoplasty used should fit the needs of the particular patient and often it can be a one stage operation. Care must be given to prevent scoliosis. This operation rarely develops late complications. The disadvantages of thoracoplasty are deformity, impairment of respiratory function, and often a multiple stage procedure.

Pulmonary resection has become the outstanding method in the treatment of pulmonary tuberculosis and if medical means of treatment become sufficiently good in the future perhaps no other method of treatment will be necessary. The more localized the resection the more suitable is this method of treatment. When the lesion is sufficiently localized there will be little loss of pulmonary function so long as complications are avoided; no secondary procedure will be necessary to reduce the volume of the pleural space and the mortality rate will be low. If this reasoning is carried far enough it is logical to expect that all patients will be cured of their tuberculosis by medical means and surgery will be needed only to repair anatomic structural damage caused by the disease. At the present time the indications for pulmonary resection in the treatment of pulmonary tuberculosis are (a) persistent small localized pulmonary lesions of any type, especially cavitary; (b) lesions not suitable for collapse therapy, solid-like lesions, and major bronchial lesions resulting in tension cavity, giant cavity, atelectasis, fibrotic bronchial stricture, bronchiectasis and destroyed lung; (c) instances in which collapse therapy has failed to heal the lesion; (d) where the patient is thought to be cured but where structural changes in the tracheobronchial tree necessitate surgery. It should be emphasized that excisional surgery can be made applicable to any type of pulmonary lesion. Consequently, there will be constant conflict between the indications for collapse therapy unless collapse therapy is definitely contraindicated because of the type of lesion. As more care is given to the type of lesion selected for collapse therapy and as this type of therapy is used less frequently the indication for excision after collapse therapy failure will become less important. There will be disagreement with regard to the indications for cavitary drainage and resection unless the physical condition of the patient beyond question rules out major surgery. The most important controversy will arise between the indications for medical therapy and the indications for pulmonary resection.

The conflict between the indications for medical therapy and pulmonary resection is extremely important and cannot be answered satisfactorily at this time. When is a patient cured of pulmonary tuberculosis by medical therapy? Do small localized fibrotic or solid lesions need resection? How long should medical therapy be carried on before resection is undertaken? Should the initially found localized pulmonary lesion be resected without a prolonged medical regimen of therapy? A true and proven basic principle in medicine dictates that surgery should not be used if there will be satisfactory response to medical treatment. Therefore, the concept of applying excisional therapy in pulmonary tuberculosis before a trial at medical management seems entirely unjustified.

When pulmonary resection for pulmonary tuberculosis is carried out there must always be some procedure followed to reduce the volume of the pleural space if the resection is either a lobectomy or a pneumonectomy. This reduction in volume of the pleural space should equal the volume of the lung resected in order to avoid any overdistention of the remaining lung tissue. For lobectomy there may be used either simultaneous, or subsequent thoracoplasty, plastic prosthesis, or detachment of the diaphragm with reattachment at a higher level. For pneumonectomy the pleural space can be reduced by thoracoplasty, simultaneous or subsequent, or by prosthesis. These procedures do not make resection more simple.

Since there are so many variable factors in the treatment of pulmonary tuberculosis there will always be an honest difference of opinion concerning the proper treatment to be given the particular patient under discussion.

BIBLIOGRAPHY

1. Adie, George C., Childress, William G., Brezing, Herman J., and Taylor, Donald, Late Results in the Treatment of Pulmonary Tuberculosis by Thoracoplasty, J. Thoracic Surg. **23:** 92, 1952.
2. Auerback, O. and Green, H., The Pathology of Clinically Healed Tuberculous Cavities, Am. Rev. Tuberc. **42:** 707, 1940.
3. Bailey, C. P., Glover, R. P., and O'Neill, T. J. E., Comparison of Results in Two Hundred Consecutive Resections for Pulmonary Tuberculosis, One Hundred without Streptomycin Therapy and One Hundred with Therapy, J. Thoracic Surg. **18:** 36, 1949.
4. Banyai, A. L., Pneumoperitoneum, C. V. Mosby Co., St. Louis, 1946, pp. 61–62.
5. Brantigan, O. C., Thoracoscopy and Closed Intrapleural Pneumonolysis, Am. Rev. Tuberc. **59:** 240, 1949.
6. Brantigan, O. C. and Rigdon, H. L., Resections of the Lung in the Treatment of Pulmonary Tuberculosis, Arch. Surg. **60:** 520, 1950.
7. Brantigan, O. C., Thoracoplasty in the Treatment of Pulmonary Tuberculosis, Am. Surgeon **18:** 6, 1952.
8. Brantigan, O. C., Lucite Ball Plombage (To be published).
9. Brantigan, O. C., Pulmonary Resection in Pulmonary Tuberculosis (To be published).
10. Chamberlain, J. M. and Klopstock, R., Further Experiences with Segmental Resection in Tuberculosis, J. Thoracic Surg. **20:** 843, 1950.
11. Crow, H. E., and Whelchel, F. C., Diaphragmatic Paralysis and Pneumoperitoneum, Am. Rev. Tuberc. **52:** 367, 1945.
12. Day, J. C. et al., Resection in Treatment of Pulmonary Tuberculosis, J. Thoracic Surg. **20:** 854, 1950.
13. Dressler, S., Bronfin, G., and Crow, J., Pulmonary Function Studies before and after Extrapleural Pneumonolysis with Plombage, J. Thoracic Surg. **19:** 938, 1950.
14 Gaensler, Edward A. and Strieder, John W., Pulmonary Function before and after Extrapleural Pneumothorax, J. Thoracic Surg. **20:** 774, 1950.
15. Gaensler, Edward A., Analysis of the Ventilatory Defect by Timed Capacity Measurements, Am. Rev. Tuberc. **64:** 256, 1951.
16. Gale, J. W., Dickie, H. A., and Curreri, A. R., Pulmonary Resection in Treatment of Tuberculosis, Am. Rev. Tuberc. **59:** 10, 1949.
17. Gaubatz, E., Ueber Funktionspruefungen vor und nach der Operativen Kollapstherapie II. Funktion Spruefungen zur Pneumonolyse, Beitr. Z. Klin. Tuberk, **91:** 201, 1938.
18. Gordon, By Personal Communication.
19. Hardy, J. T., Jr., Bergstrom, W. H., and Browning, R. H., Percentage of Permanent Diaphragmatic Paralysis Following Phrenicotripsy, Am. Rev. Tuberc. **58:** 646, 1948.
20. Kinsella, T. J., and others, Thoracoplasty in Treatment of Pulmonary Tuberculosis, Am. Rev. Tuberc. **59:** 113, 1949.
21. Krynski, B., Survey of Thoracoplasties at Sea View Hospital over a Five Year Period (1937–1942), Quart. Bull. Sea View Hosp. **9:** 144, 1947.
22. Lees, W. N. et al., Results in 278 Patients Who Had Modern Type of Thoracoplasty for Tuberculosis. Read before the Annual Meeting of The American Association for Thoracic Surgery, 1951.
23. Leiner, George C. and Abramowitz, Sol, Spirometric Studies in Pneumoperitoneum, Am. Rev. Tuberc. **65:** 465, 1952.
24. Loesch, John, Closure and Healing of Tuberculous Cavities, Am. Rev. Tuberc. **58:** 322, 1948.
25. Medlar, E. M., Pathogenetic Concepts of Tuberculosis, Am. J. Med. **9:** 611, 1950.
26. Meyers, D., and Silver, A. M., Pneumonectomy in Treatment of Pulmonary Tuberculosis, Quarterly Bull. Sea View Hospital, **12:** 10, 1951.
27. Ottosen, P., Popp, C., Beatty, A. J., and Buckingham, W. W., One Hundred Thirty Consecutive Thoracoplasties, Evaluation of Results in Different Types of

Pulmonary Tuberculosis, J. Thoracic Surg. **21:** 202, 1951.

28. Overholt, Richard H., Wilson, Norman J., and Gehrig, Leo J., The Place of Pulmonary Resection in the Treatment of Tuberculosis, Dis. Chest **21:** 32, 1952.
29. Pagel, W. and Simmonds, F. A. H., The Healing of Cavities, Am. J. M. Sc., **197:** 281, 1939.
30. Pagel, W. and Simmonds, F. A. H., Cavity Healing and Bronchial Occlusion, Am. J. Med. Sc. **203:** 177, 1942.
31. Pinner, Max, Healing of Tuberculosis Cavities, Am. Rev. Tuberc. **42:** 731, 1940.
32. Rubin, M. and Klopstock, R., Influence of Type of Disease on Results of Thoracoplasty in Pulmonary Tuberculosis, Am. Rev. Tuberc. **60:** 273, 1949.
33. Shields, D. O. and Chapman, J. S., Elective Resection of Nodular Tuberculosis. Read at 32nd Annual Meeting of The American Association for Thoracic Surgery.
34. Seiler, H. H., and Murphy, J. D., Permanence of So-called Temporary Phrenic Nerve Paralysis, Am. Rev. Tuberc. **63:** 81–84, 1951.
35. Sive, Eugene, Bogen, Emil and Dolley, Frank S., Pulmonary Resection for Tuberculosis, J. Thoracic Surgery **23:** 619, 1952.
36. Steinlin, H., Atemfunktionsprufung bei Temporarer Phrenikusausschaltung Verbunder mit Pneumperitoneum, Schweiz. Ztschr. Tuberk. **3:** 32, 1946.
37. Sweet, R. H., Lobectomy and Pneumonectomy in Treatment of Pulmonary Tuberculosis, J. Thoracic Surg. **19:** 298, 1950.

ETIOLOGICAL CONSIDERATIONS AND THE PREVENTION OF RHEUMATIC FEVER[1]

COLIN M. MacLEOD, M.D.[2]

The large body of evidence that has been collected over many years has made it clear that hemolytic streptococci of Lancefield's Group A are the primary incitants of rheumatic fever. It was to be hoped that with identification of the prime villains, the Group A streptococci, rapid progress would be made in discovering the mechanism whereby they produce the disease and devising methods for preventing or ameliorating the damage. We are still operating on a basis of empiricism, though very distinct progress in prevention has been made.

The sequence of events in the development of rheumatic fever is infection by Group A streptococci, usually of the throat, followed by a latent period of variable length most commonly about two to three weeks, and then the appearance of the manifestations of rheumatic fever. Streptococci cannot be recovered from the rheumatic lesions and furthermore the disease may remain active even though the inciting streptococci can no longer be isolated from the patient. Persons who have had one or more attacks of rheumatic fever, have a much greater susceptibility than normal to developing the disease following re-infection with streptococci, but can be protected by the administration of antimicrobial drugs as was shown originally by studies carried out simultaneously in Baltimore by Thomas and France (1) and in New York by Coburn and Moore (2).

The most popular explanation of the relationship of streptococci to rheumatic fever is to be found in the "allergic hypothesis." According to this view, as a result of acute infection, sensitization to streptococci or their products occurs to become manifest at the end of the latent period by the development of rheumatic fever. The most often quoted evidence for the allergic hypothesis may be summarized somewhat as follows:

(1) The latent period fits in well with the concept of an allergic etiology, this interval being required for the development of hypersensitivity and its pathological manifestations.

(2) The joint manifestations of rheumatic fever

---

[1] Presented before the Baltimore City Medical Society in Co-sponsorship with the Heart Association of Maryland on October 17, 1952.

[2] Department of Microbiology, New York University College of Medicine, New York City.

are closely similar to those in the known allergic condition, serum sickness, and respond well to the same drugs—e.g. salicylates or amidopyrin.

(3) The skin rashes are similar to those found in certain allergic conditions.

(4) Patients with rheumatic fever tend to have higher titers of antibodies for streptococcal products (e.g. antistreptolysin O and antistreptokinase), than patients who have recovered from a streptococcal infection without developing rheumatic fever. It has been argued that the individuals likely to develop rheumatic fever should be precisely those whose immunological response is the greatest, since they would be the most likely to develop the highest degree of hypersensitivity. Along with the generally higher levels of antibodies to streptococcal products the rheumatic fever subjects show marked dermal hypersensitivity to streptococcal products.

(5) The occurrence in man and production in experimental animals through hypersensitivity reactions of lesions similar in some respects to those found in rheumatic fever, though not identical. This has been most carefully explored in recent years through the studies of Rich and Gregory (3).

(6) The persistence of activity of the disease can be rationally explained by the allergic hypothesis since the offending antigen might easily persist in the tissues of the hypersensitive subject even though the initiating streptococci themselves had long since disappeared from the throat.

Other observations could be cited that support the allergic theory, but the foregoing seem to be the most important and those upon which most stress has been placed by the proponents of that theory. To some, however, the allergic theory has long seemed unsatisfactory because its basis is mainly analogy and for the scientific reason that it is desirable, if progress is to be made, that other explanations be sought which might fit the facts and be susceptible to experimental attack.

One of the discrepancies in the allergic theory is the specificity of Group A streptococci in initiating the disease. True, there have been a number of reports in which it has been claimed that rheumatic fever may follow vaccination against smallpox and other immunizing materials, or may follow dysentery, malaria and even traumatic injury. Unfortunately, in these instances the participation of concurrent or antecedent streptococcal infection has not been rigorously excluded by careful bacteriological and immunological studies. This is a serious inadequacy particularly since we know that the initiating streptococcal infection can be so mild as to escape clinical detection and go unrecognized unless careful laboratory examination is made. For example, Rammelkamp and his coworkers (4) have reported that about 40 per cent of the patients with rheumatic fever observed by them in a military post suffered from antecedent streptococcal infections so mild that the patients did not seek medical attention despite its ready availability. In other words, absence of overt and clinically recognizable streptococcal infection does not mean that it did not occur. Exclusion can be made only on the basis of bacteriological and immunological studies.

For these reasons the validity of the reports on rheumatic fever that has been precipitated by agencies other than Group A streptococci is open to question.

If the unique role of streptococci is accepted, it is pertinent to inquire as to how this fits in with the allergic hypothesis. All persons, practically speaking, develop hypersensitivity, of either the immediate or delayed type to a variety of antigenic or haptenic materials, both bacterial and non-bacterial in origin, but none that we know, with the possible exception of allergy to Group A streptococcal products leads to rheumatic fever. If allergy of the immediate or hay fever type is the underlying state in rheumatic fever, it follows that the antigenic substance and its corresponding antibody which gives rise to the sensitization, behave differently than any other antigen-antibody combination that we know of.

If allergy of the delayed or tuberculin type is operative, once again a unique type of interaction between the streptococcal antigen and the sensitized cells or their products must be invoked. It is by no means impossible that such unique hypersensitivity reactions take place. On the other hand there is no evidence for their existence up to the present.

Another point which casts some doubt on the allergic hypothesis is that of recurrent attacks in the same individual. The latent period during the initial attack has been explained as the time required for the development of hypersensitivity and its manifestations. One might expect, however, that the latent period would be very much shorter between the initiating streptococcal infection and a second attack since hypersensitivity has already been established. This does not seem to be the case, because the latent period in second and subsequent attacks in the same individual does not appear to be significantly different than that of the primary attack of rheumatic fever.

It is recognized that the objections to the allergic theory that have been mentioned do not in themselves discredit it. However, they are sufficient to stimulate thought as to other possible mechanisms. Is there any other hypothesis which might fit the known facts?

In considering alternative hypotheses it has seemed to us that in general the evidence is as compatible with the direct action of a toxin elaborated by Group A streptococci as it is with an allergic mechanism. According to this view the infecting Group A streptococci growing in the pharynx elaborate a specific "toxin" which is absorbed into the general circulation to produce its effects throughout the body. It may be objected that the long latent period is incompatible with the action of a toxin absorbed into the blood. Delayed action of toxins is well known, however. One of the best examples is that of diphtheria where the evidences of toxic neuritis with paralyses usually occur during the second or third week of convalescence from the acute pharyngeal or nasal infection. Moreover, the cardiac manifestations of diphtheria, especially interstitial myocarditis, are also late manifestations. The latent period between the streptococcal infection and the appearance of rheumatic manifestations is closely paralleled in the secondary manifestations of diphtheria where a specific toxin is known to be functioning.

The majority of pathologists who have studied rheumatic fever have emphasized the Aschoff nodule as characteristic of the disease and a great deal of attention has been paid to defining what does or does not constitute an Aschoff body. If one accepts the specificity of the Aschoff nodule, which appears reasonable, it would seem to be an almost necessary corollary that there should be a specific inciting agent such as a toxin that is responsible for its production.

At first sight, the failure of one attack of rheumatic fever to confer immunity against a second attack might appear to argue strongly against the participation of a streptococcal toxin. If the hypothetical toxin is antigenic, as in the case of diphtheria toxin, recovery from the disease should leave the individual immune. This is not true in the case of rheumatic fever, so that if a toxin is involved, it is possible that it is nonantigenic. Do such toxins exist in bacteria and specifically in Group A streptococci?

Group A streptococci produce 2 hemolytic toxins known respectively as streptolysin O and streptolysin S. Although their activity can be conveniently measured by hemolytic reactions it should not be inferred that these toxins are active only upon red blood cells. There is good evidence, particularly in the case of streptolysin O, that the toxin affects other types of cell. Streptolysin O is an excellent antigen so that most individuals who have had a streptococcal infection develop antibodies to it, so-called antistreptolysin O. Streptolysin S is an entirely distinct substance and is the toxin which is responsible for the familiar β-hemolysis produced by Group A streptococci growing on blood agar plates. For a number of years streptolysin S was believed to be antigenic, although somewhat weak in this respect. Recent evidence, however, particularly from the work of Humphrey (5) and of Stollerman and Bernheimer (6), has shown that streptolysin S is not antigenic in rabbits whether elaborated in the tissues by streptococci during infection or upon injection of the isolated material.[3] Similarly, following recovery from streptococcal infection no evidence of antibody to streptolysin S appears in patients.

Although streptolysin S, which is a powerful toxin, is not antigenic, the blood of man and animals contains a substance or substances which inhibit it. This we have called streptolysin S inhibitor (7). The inhibitor is associated with the lipoprotein complexes of serum and appears to depend upon the content and disposition of lecithin in such complexes. It should be emphasized that the inhibitor is not an antibody.

Todd, Coburn and Hill (8) reported in 1939 that "antistreptolysin S" titers during the course of rheumatic fever tended to be low when the clinical symptoms were most severe. Since "antistreptolysin S" appeared to be a specific antibody, the fall in titer during rheumatic activity might be considered as an abnormal antibody response.

Following the discovery that the inhibitor of streptolysin S in serum is not an antibody it was of interest to reinvestigate its behavior during rheumatic fever (6). Serum was obtained from patients during the acute phase of the disease and in convalescence and the content of streptolysin S inhibitor was measured. This was found to be below normal levels in 80 per cent of patients during the acute phase of the disease, returning to normal when convalescence became established. It should not be inferred that this depression of inhibitor levels is unique to rheumatic fever. Some patients with other diseases also show depressed levels and in some the levels may be increased. It is of interest, however, that of the diseases studied to date, acute rheumatic fever is the only one in which a high proportion of patients have levels consistently below normal. It is of significance that in acute streptococcal pharyngitis uncomplicated by rheumatic fever, the levels remain normal (6).

It is not intended to leave the impression that streptolysin S bears a specific etiological relationship to rheumatic fever or that it is the hypothetical specific toxin responsible for the lesions. There is no evidence that this is so. Streptolysin S, however, does fulfil certain of the requirements and for this reason merits further investigation. It is our hope that inhibitors more easy to handle than lipoprotein complexes may be found so that a more direct test of its possible role in the disease may be made by therapeutic trial. For example, if streptolysin S has an etiological role, an inhibitor of this toxin might be expected to exert a beneficial effect on the symptomatology and progress of rheumatic fever.

The most ideal method for the prevention of rheumatic fever is the prevention of the antecedent streptococcal infection. There are two general methods that have been suggested for accomplishing this aim—through specific immunization and by means of chemoprophylaxis. Prophylaxis by means of sulfonamides was shown to be successful in the prevention of recurrences in rheumatic children through the independent studies of Thomas and France (1) and of Coburn and Moore (2) which were published in 1939. The original observations have been abundantly confirmed by other investigators using sulfonamides and more recently penicillin. This constitutes a major advance in that it is now possible to protect the rheumatic child from further attacks of the disease, and it seems probable through the use of materials such as long-acting penicillin of the type of dibenzyl penicillin that many of the practical difficulties can be minimized (9).

Protection of large population groups against streptococcal infections by means of sulfonamide chemoprophylaxis has also been attempted, at first with some success, but later failing because of the widespread emergence of sulfonamide-resistant strains of streptococci. The administration of chemoprophylactic agents to the general population can be justified only in the presence of an epidemic state and then only if careful laboratory control is used. The danger of sensitivity reactions and the risk of developing a drug-resistant bacterial population are definite restraints in addition to the tremendous cost of such a program and the difficulty of administration. Circumstances have arisen in the past, however, and are likely for the future, which fully justify chemoprophylaxis of streptococcal infections.

---

[3] It is possible that antibodies are produced to streptolysin S, but do not neutralize its toxic action. This occurs in the case of antibodies to certain enzymes which combine with the enzyme but do not inhibit enymatic activity.

Another approach to the prevention of rheumatic fever is that introduced by Massell, Dow and Jones (10) who first showed that penicillin treatment of existing streptococcal disease in hospitalized rheumatic subjects will prevent recurrences. This approach has been extended by Rammelkamp and his coworkers (4) at the Streptococcal Disease Laboratory at the Warren Air Base in Wyoming. In their study approximately 1000 patients with exudative tonsillitis were treated with depot penicillin administered early in the course of the disease and the incidence of overt rheumatic fever with latent period of less than 35 days compared to that in a control group of the same size to whom penicillin was not given. The data are very impressive since 23 cases of frank rheumatic fever occurred in the untreated control group whereas only one patient in the treated group developed the disease. The same investigators (4) have reported similar results for aureomycin treatment of acute exudative tonsillitis. Penicillin would appear to have an advantage since in adequate dosage it rapidly and permanently rids the pharynx of streptococci, but this is not the case with aureomycin. The use of penicillin or aureomycin in this way has definite limitations, however, in the prevention of rheumatic fever since, as previously noted, 40 per cent of the individuals in the age group studied by Rammelkamp and coworkers (4) who developed rheumatic fever did not have symptoms severe enough at the time of their streptococcal infection to cause them to seek medical attention. The best that can be hoped for is therefore a reduction in incidence of rheumatic fever of approximately 50 per cent by treating the acute streptococcal infection.

Attempts have been made to prevent streptococcal infection by specific immunization. To date these attempts have been through the use of whole bacterial vaccines and the results have not been particularly promising. It should not be concluded, however, that specific immunization is forever an impossibility, although the difficulties are formidable. In the first place there are many immunological types of Group A streptococci, immunity is type specific and rheumatic fever can follow infection with any of the more than 40 types. A mitigating consideration is that in general only a limited number of types are responsible for most cases of infection in a given area and at a given time, so that immunization would not necessarily involve the use of antigenic materials from all the known types even though that were possible.

A second difficulty is that a large proportion of the normal population is hypersensitive to Group A streptococci and their products which makes the use of whole bacterial vaccines a somewhat heroic procedure. The studies of Lancefield have shown that each of the many types of Group A streptococci contains a specific and different surface protein which she has called M protein. Virulent streptococci contain the M protein and antibodies to the M protein of a particular type protect against infection by streptococci of that type. M protein from a limited number of types has been prepared in partially purified form and has been shown to be moderately antigenic upon injection into experimental animals. It is possible through improved methods for preparing M proteins in pure state and incorporation in media which will enhance their antigenicity, that immunity to streptococcal infections might be attained in man. No other method for obtaining specific immunity would appear to hold promise. It should be emphasized that this is yet a far goal and a rather discouraging one at present, but nonetheless worth working toward.

An additional approach to prevention might come through discovery of the nature of the component or components of Group A streptococci that are responsible for the disease, whether enzymes, toxins or antigens distinct from known toxins or enzymes. If the offending substance were identified and if it is antigenic, possibilities of immunization can be visualized. As yet, however, such an approach to prevention is entirely in the realm of speculation.

SUMMARY

1. The allergic hypothesis of the etiology of rheumatic fever has been examined and certain of its shortcomings have been pointed out. It is suggested that rheumatic fever may represent the effect of a specific toxin elaborated by Group A streptococci and that the hypothetical toxin may not be antigenic.

2. Various methods for the prevention of rheumatic fever have been reviewed. Although no single method yet envisaged can be completely successful, a substantial reduction can be expected through the application of knowledge available at present.

BIBLIOGRAPHY

1. Thomas, C. B., and France, R., Bull. Johns Hopkins Hospital, 1939, **64:** 67.
2. Coburn, A. F., and Moore, L. V., J. Clin. Invest., 1939, **18:** 147.
3. Rich, A. R., and Gregory, J. E., Bull. Johns Hopkins Hospital, 1943, **72:** 65.
   Rich, A. R., and Gregory, J. E., Bull. Johns Hopkins Hospital, 1943, **73:** 239.
   Rich, A. R., and Gregory, J. E., Bull. Johns Hopkins Hospital, 1944, **75:** 115.
4. Rammelkamp, C. H., Houser, H. B., Hahn, E. O., Wannamaker, L. W., Denny, Floyd W., and Eckhardt, G. C., in Rheumatic Fever, a Symposium edited by Lewis Thomas, University of Minnesota Press, 1952.
5. Humphrey, J. H., Brit. J. Exp. Path., 1949, **30:** 345.
6. Stollerman, G. H., and Bernheimer, A. W., J. Clin. Invest., 1950, **29:** 1147.
7. Stollerman, G. H., Bernheimer, A. W., and MacLeod, C. M., J. Clin. Invest., 1950, **29:** 1636.
8. Todd, E. W., Coburn, A. F., and Hill, A. B., Lancet, 1939, **2:** 1213.
9. Stollerman, G. H., J. A. M. A., 1952, **150:** 1571.
10. Massell, B. J., Dow, J. W., and Jones, T. D., J. A. M. A., 1948, **138:** 1030.

DIAGNOSIS AND MANAGEMENT OF COMMON GYNECOLOGICAL PROBLEMS[1]

WALTER J. REICH, M.D., M. WM. RUBENSTEIN, M.D. AND JEROME B. REICH, M.D.[2]

TRICHOMONAS VAGINITIS

Among the most common causes for vaginal discharge often associated with vaginitis are those due to either trichomonas or monilia (yeast). Clinically, trichomonas vaginitis is characterized by a yellowish, bubbly malodorous discharge, often associated with itching. The vaginal wall may be injected, only slightly, or even up to an angry red, and tender and painful. Indeed, trichomonas vaginitis may produce acute, painful distressing symptoms. The causative organism is the parasite, trichomonas vaginalis, and is easily identified microscopically, in a hanging drop made from a slight amount of discharge mixed with a drop of warm normal saline or water. The parasite with its characteristic flagellum or tail can be seen swimming about, as a rule.

---

[1] Courtesy of the Maryland Academy of General Practice. Presented before this Association at its Annual Scientific Assembly, October 9, 1952, Lord Baltimore Hotel, Baltimore.

[2] From the Department of Gynecology, Cook County Hospital; Grant Hospital; Cook County Graduate School of Medicine; Chicago Medical School; Chicago, Illinois.

In combating this condition, both the prophylactic treatment and reinfection sources must be considered, as well as the active treatment. Bedpan splash, contamination from the stools, poor hygiene in general, as well as reinfection from the male's prepuce, urethra, or prostate, or from her own Skene's ducts, urethra or rectum. The active treatment starts by cleansing the vagina with a liquid made up of one tablespoon of a 20% sodium caprylate solution to one quart of water. The same mixture is used as a douche nightly, for 5 consecutive nights, followed by vaginal insertion of a suppository of milibis (15% arsenic and 42% bismuth). Twice weekly, milibis powder is insufflated in the office, via an open speculum. Treatment is carried out throughout the month, including the menstrual period.

YEAST (MONILIA) VAGINITIS

Yeast vaginitis is caused by the monilia organism, and is characterized by patchy grey-white flecks that cover a slightly injected or sometimes bleeding underlying mucosa. Itching and discharge are usually present.

It has often been said that trichomonas vaginitis resembles the strawberry tongue of scarlet fever, and yeast vaginitis the throat of diphtheria.

Using 10% sodium (or potassium) hydroxide as the hanging drop solution, the characteristic yeast structure with its branches and buds is easily noted.

The naprylate treatment of yeast vaginitis has been very successful. At the initial visit the vagina is cleansed with a solution made up of one tablespoon of 20% naprylate solution to one quart of water. At home the patient douches nightly with a similar solution, followed by intravaginal insertion of naprylate ointment. Twice weekly naprylate powder is insufflated, in the office.

ELECTROCAUTERIZATION OF THE CERVIX

The electrocautery is paramount for the treatment of chronic endocervicitis, with or without erosion. Clinically this condition is characterized by a white mucoid discharge, annoying as a rule only because of its presence. Before simple cervicitis and erosion are diagnosed, the patient's history is carefully evaluated, and a cytological cervico-vaginal (Papanicolaou) smear, and/or biopsy is taken in order to rule out possible carcinoma of the cervix. The following general principles, only if adhered to, establish the justifiable term "simple cautery":

1. Cauterize the patient about one week postmenstrually. This is the optimum time because the immediate post- or premenstrual vascularity may lead to possible hemorrhage. We have seen this complication several times, and one patient required as many as three blood transfusions.

2. The color of the electrocautery tip is maintained at a dull cherry red as observed in ordinary room light, not under the spot light. Too hot a tip causes deeper burns, more sluff, greater chance for bleeding.

3. To minimize possible vaginal burns, the "cold cautery" is used. The tip is dipped into cold water before being applied to the cervix.

4. Every cauterization consists of a canal cautery, regardless of whether an erosion, eversion or ectropion are also present or not. The canal cautery is done first, cauterizing the entire length of the canal up to the internal os. Next, the red, eroded area is touched up by the electrocautery tip.

Douching and intercourse are forbidden for two weeks in order not to interfere with the slough and cause possible bleeding. During this time there is usually an increased discharge, often foul-smelling; the patient is told about this in advance. Douching with a mild acid solution is allowed after the second week.

5. The cervical canal is kept open by weekly dilatation. This is important, and prevents scarring and stenosis with its possible complication of leucometra, or pyometra, or hematometra, etc. A simple cotton applicator dipped in 10% silver nitrate or negatan solution often suffices.

It takes about six to eight weeks for complete epithelialization. Never recauterize before three months. A cervix that continues to bleed after cauterization may also have had a) too deep and too hot a cautery. b) Cervix was acutely infected. c) Recauterized too soon after recent cautery, and d) possible associated carcinoma of the cervix, previously undetected.

VAGINOSCOPY

The vaginoscope has been brought to light recently because of its practical value in detecting and assisting in the removal of foreign bodies of the vagina. Especially has this been of use in cases of unexplained vaginal discharge in the young female child. When an x-ray does not clearly reveal whether the foreign body is in the bladder or vagina, vaginoscopy may be the answer, and also the retrieving instrument. An otoscope with a properly shaped speculum piece is very adaptable for this work.

CYTOLOGICAL SMEAR FOR CARCINOMA OF THE UTERUS

One of the most recent advances in detection of early carcinoma of the uterus—particularly of the cervix—can be attributed to the cytological (Papanicolaou) smear method. A cervix with an erosion or even a cervix that looks normal, cannot be definitely labeled as one that does not seat a squamous cell carcinoma. There are too many instances where an innocent looking cervix or a mild erosion was already the site of an early squamous carcinoma. Whether a smear is taken or a biopsy, matters not. It is important that some form of screening be used. The cytological smear can be easily performed in the office and because of its non-surgical and painless approach, may perhaps be the one of choice for screening. Materials needed are: a) fixative which is usually in a bottle, consisting of equal parts of 95% alcohol (ethyl or isopropyl), and ether. b) Means of obtaining the smear, such as a wooden spatula, cotton swab, or anything that might be available or practical for the purpose. And c) slides. Preferably, the patient does not douche. We attempt to obtain material from 1.) the squamocolumnar or erosio-normal junction, long known to be the starting site of early squamous carcinoma; and 2.) from the external os; and 3.) from the posterior fornix. The material is spread on two slides, being careful not to smear them too thickly or to overlay the smear, and then immediately put into the fixative. The latter is a very important point, in order to prevent the cells from drying. Frosted-end slides are practical, the name is written on the slide in ordinary lead-pencil. The slides are prevented from rubbing with each other by putting an ordinary paper clip on one end.

The slides are then removed after being in the fixative for a minimum of 30 minutes, allowed to dry, wrapped in kleenex and then either delivered or mailed to any experienced cytologist. It might be mentioned that a vaginal speculum is always employed to expose the cervix unless mechanically impossible. Staining is done by using the trichrome stain of Papanicolaou. Reports are listed as negative, benign, atypical suspicious, malignant, or definitely malignant. The final corroboration must always lie with the histological section. A positive smear must be followed by a biopsy. It may be necessary to do a ring biopsy and get serial sections in order to detect the very early, often preinvasive carcinoma. A positive smear done by an experienced cytologist must not go unheeded. Search by biopsy and serial sections must follow.

The very early, preclinical squamous cell carcinoma, often carcinoma in situ, is the one most important to detect. For it is this carcinoma that lends itself to, perhaps, even a cure. Every doctor's office should be a cancer detection center. When the rather commonly occurring carcinoma of the cervix, so important because of its devastating pathogenic nature, can possibly be detected by a routine screening, it may be reiterated —" Routine smears might be the answer."

A Most Important Consideration in All Cases of Vaginal Bleeding

As the underlying cause for unexplained vaginal bleeding, one must keep in mind that the disturbance may be in the blood and blood-forming apparatus. Thrombocytopenic purpura has been brought to attention in just such instances. The young adolescent girl with irregular, often menorrhagic periods, is usually looked upon as having a "functional" or "glandular" problem. Yet the underlying cause may be that of a marked thrombocytopenia, with its low or even absent platelets, large spleen, prolonged bleeding time, etc. Indeed, such cases have occurred, gone undiagnosed, and unfortunately, expired. On the other hand, gratifyingly, if the diagnosis is made in time, splenectomy may be life saving. It may be well advised that in any meno-metrorrhagic patient, a routine platelet count and bleeding time be done, irrespective of the pelvic pathology.

Management of Spastic, Tense, Rigid Hymen

In some cases the underlying cause for sexual incompatibility, especially in the newly married couple may be due to small rigid hymen with an associated, tense, spastic, perineal body. The treatment is not only excision of the hymen, but also an incision downward into the perineal body, through the base of the superficial compartment and the base of the triangular ligament. With a finger in the rectum as a guide, a cut is made down to the external sphincter. It is almost a perineal repair in reverse, in that the cut edges are sutured transversely, thus enlarging the vaginal introitus opening. Healing is usually by primary intention and has been very satisfactory in numerous cases. This is followed by weekly dilatations, starting two weeks post-operatively, and continued for about two months. A vaginal speculum is used.

PARENTERAL NUTRITION[1]

WILLIAM R. WADDELL, M.D.[2]

There is unanimous agreement that many patients would benefit greatly from more adequate parenteral caloric supply used as a supplement to the glucose and protein preparations that have become standard therapeutic preparations. There is still great confusion at the clinical level, however, concerning the importance that can be attached to caloric intake in relationship to other dietary essentials and the process of convalescence. The body's economy is so arranged as to withstand short fasts without any perceivable ill effects, and even relatively long periods of sub-maintenance caloric intake are often not harmful. As a consequence caloric intake is sometimes among the last considerations in any therapeutic program. There are many other patients, nevertheless, whose convalescence could be speeded, or whose life could be spared, if adequate calories could be provided parenterally during periods when the gastrointestinal route cannot be used for alimentation in the usual manner. It is therefore worthwhile to examine briefly the means at our disposal for parenteral feedings and discuss the advantages and limitations of each, particularly as they relate to caloric requirements and our ability to satisfy them.

There are many dietary essentials but none occupies a more fundamental position than calories, representing as they do the thermal units which supply energy for intermediary metabolism. The caloric intake must obviously be in excess of at least basal requirements or the body will sacrifice fat, carbohydrate and protein, to obtain energy. In man, 1600 to 2000 calories per day must be available to maintain equilibrium and to this must be added rather large increments imposed by departure from the normal basal state. One of the aims, therefore, of any nutritional program, parenteral or oral, must be the provision of adequate caloric intake.

---

[1] Courtesy of the Maryland Academy of General Practice. Presented before this Association at its Annual Scientific Assembly, October 9, 1952, Lord Baltimore Hotel, Baltimore.

[2] Department of Nutrition, School of Public Health, Harvard University, Boston, Massachusetts.

Not only is the energy intake in itself important in terms of total calories but significant relationships exist between calorie supply and the physiologic utilization of different foodstuffs for purposes of tissue repair, growth, work, and maintenance of cell life. The concept of a dynamic relationship between energy intake and metabolism of both endogenous and exogenous protein seems certainly established. Practically, this means that on an adequate protein intake caloric supply becomes the determining factor in nitrogen balance, i.e. protein sparing and/or synthesis versus protein breakdown. Similarly on inadequate protein intake the amount of additional energy supplied, whether derived from fat or carbohydrates, bears a direct linear relationship to nitrogen retention. Conversely, the withdrawal of energy in the form of either carbohydrates or fat results in impaired nitrogen balances. [For a detailed review of the relationships which exist between energy intake and protein metabolism see H.N. Munro reference (1).]

Common sense, years of clinical experience, and detailed studies all indicate that ordinarily no harm comes from short complete or partial fasts such as follow acute illness, operation or trauma (2). The fat, protein, and carbohydrate stores of the body are available. The sharpest limitation is in the carbohydrate reserve. Even previously well-nourished individuals have only a limited supply of stored carbohydrate and since a continuous source of this foodstuff is necessary to maintain oxidative requirements of the body's cells, exogenous supplies must be maintained or the sacrifice of considerable tissue protein and fat will occur to meet energy needs. Fortunately, dextrose solutions are widely available, simple to administer, and it is usually not difficult to provide as much as 200 grams of carbohydrate daily by the intravenous route. For short term dietary restriction nothing more is necessary aside from maintenance of electrolyte and fluid requirements. The body fats and proteins are immediately available for making up the caloric deficit and it is probably meddlesome to go to further extremes to supply a large quantity of exogenous nutriment (2, 3). This presumes that an end to dietary restriction can be accurately predicted.

Five per cent dextrose solutions are isotonic, non-irritating to veins, seldom pyrogenic, miscible with water soluble vitamins, and electrolytes. They provide 50 grams of sugar (200 calories) for each liter infused and 100–200 grams of dextrose can usually be supplied along with a patient's daily fluid requirement. This quantity of sugar will prevent severe ketosis, lessen protein wastage, and seldom be spilled out through the kidneys in appreciable amounts. Only rarely, however, can more than 800 calories be provided with this type of preparation, the quantity being limited by the fluid tolerance of the patient. Ordinarily, nothing more is needed for short-term therapy since the caloric deficit is made up from fat and protein mobilized from tissue reserves.

The carbohydrate intake can be doubled by using 10 per cent dextrose in water solutions. These are hypertonic, irritating to veins, and unless administered slowly result in wastage via the urine. Assuming a fluid intake of 3000 cc. daily about 1200 calories could be supplied from this source. This level of intake is respectable and is often sufficient, provided that some body protein and fat can be sacrificed without detriment.

The irritation to vein walls caused by hypertonic solutions sometimes becomes of considerable importance in a long-term parenteral nutrition program. The advantages of using solutions that lead to thrombosis must be balanced against the possibility that all superficial veins will become sclerosed. Should this occur one may be faced with a major obstacle to the continuation of parenteral feeding. The use of plastic catheters threaded into larger vessels circumvents these difficulties temporarily but even then thrombosis is often initiated by use of irritating solutions. Thrombi in major veins may create additional hazards of embolism. Sepsis about inlying intravenous catheters is another problem that sometimes arises from their use and when present creates a potential life endangering situation. Intravenous catheterization may be an important aid in continuing a long-term parenteral nutrition program but should never be used for convenience of either the patient or the physician when peripheral veins are available.

The place of fructose and invert sugar in our armamentarium for parenteral feeding will be established by further careful laboratory and clinical studies.

Protein solutions are also available for parenteral administration. They are prepared by the enzymatic or acid hydrolysis of whole protein and are made up of individual amino acids and/or small aggregates of amino acids. They are usually available in concentrations of 5 or 10 per cent. Their content of utilizable protein varies from 70 to 100 per cent of the total amount present. These solutions can be administered in quantities up to 2 liters per day and concentrations up to 10 per cent. The higher concentrations provoke a certain number of untoward reactions but these can be minimized by slower rate of administration. By this means 50–100 grams of protein can be supplied daily. Without entering into the controversial question of nitrogen and protein metabolism immediately after operation or trauma, it can be stated that in general if sufficient calories to cover energy requirements are concomitantly supplied from other sources, a good portion of parenterally administered protein can be used to rebuild tissue. If not, then protein supplied must be sacrificed to meet energy demands (4, 5, 6).

Alcohol has been employed for its caloric value. When completely metabolized it has a caloric value of approximately 7 calories per gram which on a volume basis amounts to 5.6 calories per cubic centimeter. The use of alcohol is limited by its action as a central nervous depressant. Alcohol can be administered in concentrations up to 10 per cent and an individual can metabolize up to 10 cc. per hour. It is necessary to exercise rather careful control over the rate of administration in order to avoid toxic symptoms. Alcohol is used in conjunction with glucose or protein solutions and when used in this manner the supplementary calories appear capable of sustaining a positive nitrogen balance (7). However, the limitations imposed by its toxic effects and the slow rate of utilization make alcohol useful mainly as a supplement to other parenteral preparations.

In summary the use of protein and carbohydrate solutions have been rather thoroughly explored both clinically and in the laboratory. Two inherent properties of these types of food impose sharp limitations upon their contribution to the caloric intake by the intravenous route. First, both protein and carbohydrate yield only 4 calories for each gram oxidized. Second, the osmotic effect of these types of molecules makes it impractical to raise their concentrations to higher levels because of sclerosis and thrombosis of veins that they produce.

The most promising approach toward overcoming these difficulties is the development of fat emulsions suitable for intravenous administration. The chief advantage of the use of fat in parenteral nutrition resides in its contribution to the energy intake. Oil-in-water emulsions do not exert any osmotic effect and high concentrations can therefore be used without damage to veins. This, coupled with the high caloric content of fat, 9 calories per gram, makes it possible to introduce considerable quantities of energy into relatively small volumes of fluid. These facts have been recognized and discussed by almost every worker that has reported investigations in this field (8–11). Inasmuch as several groups of workers have reported favorable results from clinical administration of fat emulsions (9, 12, 13, 14, 15), why then are they not more widely used? The answer is that there still remains a considerable gap between a preparation that can be produced under laboratory conditions and administered on an experimental basis and a preparation that can be manufactured and distributed in quantity.

What are the requisites of a fat emulsion suitable for clinical administration and to what extent have these requirements been fulfilled as a result of work to date?

Stability is a general term used to signify the continued maintenance of the emulsified state under a variety of conditions. Lack of stability is often spoken of as *breaking*, a term which indicates the coalescence of the minute fat particles to form larger globules. If carried to the extreme *creaming* occurs, a phenomenon with which we are all familiar. Stability is without doubt the prime consideration in preparation of clinical fat emulsions. This must be such that the emulsions can be autoclaved to attain sterility, stored for long periods, subjected to mechanical agitation and variations in temperature and finally introduced into the *human* blood stream without breaking (embolization). This ideal emulsion has been attained only in part and this fact accounts for the limited clinical use of emulsions at present. The successful infusion of approximately 500 patients by investigators in several centers attests to the stability of properly prepared emulsions on introduction into the blood stream. Autopsy material accumulated over the past 8 years on 50 cases that received intravenous fat infusions are to be reported by the group at Harvard School of Public Health (16). These studies bear out the fact that large quantities of emulsified fat can be given intravenously without embolization or abnormal accumulation of lipids within the tissues.

Most workers in this field agree that preparations that can be autoclaved must be employed to insure sterility. The breaking impetus of sterilization by autoclaving is considerable but the phospholipid stabilized emulsions most commonly used withstand high temperatures without appreciable change in the physical state of the emulsions. The necessity for autoclaving makes the use of proteins in the emulsifying system impossible and this is one of the principal differences between artifically prepared emulsions and those that leave the intestine naturally, a fact of considerable physiologic significance.

Little can be said concerning such problems as stability during transportation, wide fluctuations of temperature, etc., except that they are being studied and have not yet been solved. They constitute one of the main obstacles preventing widespread clinical use of emulsified fat for caloric purposes at the present time.

Pyrogen and other reactions: Untoward reactions to the infusion of emulsified fat are still common. Temperature elevations, sometimes associated with chills is the most frequent complication. A great deal of work has been done in an attempt to eliminate such reactions and although progress has been made, conclusive definition of the source and mode of operation of the pyrogenic factors has not been attained. It is quite clear, however, that the pyrogenic response is not inherent in the intravenous administration of emulsified fat nor the metabolism of large quantities of fat over a short period of time. Shafiroff has reported temperature elevations of less than 1.9 degrees in 87 per cent of the patients infused and rises of 2 or more degrees in the other 13 per cent (9). This is the lowest incidence of pyrogenic responses reported. Others have had pyrogenic responses in from one-half to one-third of the patients infused (14, 17, 18).

Anorexia, nausea, vomiting, headache and chest or back pain have occurred in a small percentage of each group of patients infused. The incidence of these reactions is small but their elimination along with pyrogen reactions is one of the major problems today. Johnson, Freeman and Meyer reported that thrombocytopenia developed in three patients that received multiple infusions of a 20 per cent olive oil emulsion which contained 1 per cent lecithin as the emulsifying agent. Other workers have not reported any toxic effects of this nature. Hepatic function has been studied in patients receiving multiple infusions of emulsified fat and no alterations that might be attributed to the fat were noted (14, 19).

Coincident with these studies concerning the preparation of fat emulsions suitable for intravenous administration researches have been carried out upon the utilization of such fat. Several litters of puppies have been reared, having had emulsified fat as their principal source of calories (20). Balance studies on animals (21) and patients (22) have demonstrated its utility and triglycerides labeled with isotopic carbon have shown its ready availability for caloric needs (23, 24). As much as ninety per cent of injected radioactivity can be recovered in the expired carbon dioxide.

It is obvious from this abbreviated progress report on the status of emulsified fat for parenteral nutrition that its use as a therapeutic agent must remain limited for the present but it is also quite apparent that this approach offers a most promising solution to the major problem of parenteral nutrition—the caloric supply.

BIBLIOGRAPHY

1. Munro, H. N., Carbohydrate and fat as factors in protein utilization and metabolism. Physiol. Rev., **31:** 449–488, 1951.
2. Moore, F. D. and Ball, M. R., The Metabolic Response to Surgery. Charles C Thomas, Springfield, Ill., 1952.
3. Moore, F. D., Adaptation of supportive treatment to needs of the surgical patient. J. A. M. A., **141:** 646–653, 1949.
4. Werner, S. C., The use of a mixture of pure amino acids in surgical nutrition. I. Certain pharmacologic considerations. Ann. Surg., **126:** 169, 1947. II. Effects upon nitrogen balance. Ibid., **126:** 175, 1947. III. Clinical results. Ibid., **126:** 188, 1947.
5. Elman, R., Parenteral Alimentation. Paul B. Hoeber, Inc., New York, 1947.
6. Rhoads, J. E., Protein nutrition in surgical patients. Fed. Proc., **11:** 659, 1952.
7. Rice, C. O., Orr, B. and Enquist, I., Parenteral nutrition in the surgical patient as provided from glucose, amino acids and alcohol. Ann. Surg., **131:** 289, 1950.
8. Mann, G. V., Geyer, R. P., Watkin, D. M. and Stare, F. J., Fat emulsion for intravenous nutrition in man. J. Lab. and Clin. Med., **34:** 699, 1949.
9. Shafiroff, B. G. P., Mulholland, J. H., Roth, E. and Baron, H. C., Intravenous infusions of a combined fat emulsion into human subjects. Proc. Soc. Exper. Biol. and Med., **70:** 343, 1949.
10. Meng, H. C. and Freeman, S., Experimental studies of the intravenous injection of a fat emulsion into dogs. J. Lab. and Clin. Med., **33:** 689, 1948.
11. Holt, L. E., Tidwell, H. C. and Scott, T. F. M., The intravenous administration of fat. J. Pediat., **6:** 151, 1935.
12. Gorens, S. W., Geyer, R. P., Matthews, L. W. and Stare, F. J., Observations on the use of a fat emulsion for intravenous nutrition in man. J. Lab. and Clin. Med., **34:** 1627, 1949.
13. Neptune, E. M., Jr., Geyer, R. P., Saslow, I. M. and Stare, F. J., The successful intravenous administration of large quantities of fat emulsion to man. Surg., Gyn. and Obst., **92:** 365, 1951.
14. Johnson, W. A., Freeman, S. and Meyer, K. A., Some effects of intravenous fat emulsions on human subjects. J. Lab. and Clin. Med., **39:** 176, 1952.
15. VanItallie, T. B., Waddell, W. R., Geyer, R. P. and Stare, F. J., Clinical use of fat injected intravenously. Arch. Int. Med., **89:** 353, 1952.
16. Andrus, S., Waddell, W. R., VanItallie, T. B., Geyer, R. P. and Stare, F. J., Unpublished observations.
17. Werner, S. C., Problems in the provision of calories parenterally. Trans. N. Y. Acad. Sciences, **14:** 84, 1951.
18. Stare, F. J., Unpublished data.
19. Waddell, W. R., VanItallie, T. B., Geyer, R. P. and Stare, F. J., Clinical studies on hepatic function following administration of fat emulsions. Trans. N. Y. Acad. Sciences, **14:** 78, 1951.
20. Mann, G. V., Geyer, R. P., Watkin, D. M., Smythe, R. L., Dju, D., Zamecheck, N. and Stare, F. J., Parenteral nutrition. VII. Metabolic studies on puppies infused with fat emulsions. J. Lab. and Clin. Med., **33:** 1, 1948.
21. McKibbon, J. M., Ferry, R. M. and Stare, F. J., Parenteral nutrition. II. The utilization of emulsified fat given intravenously. Jour. Clin. Invest., **25:** 679, 1946.
22. VanItallie, T. B., Manuscript in preparation.
23. Geyer, R. P., Chipman, J. and Stare, F. J., Oxidation in vivo of emulsified radioactive trilaurin administered intravenously. J. Biol. Chem., **176:** 1469, 1948.
24. Lerner, S. R., Chaikoff, I. L., Entenman, C. and Dauben, W. G., Oxidation of parenterally administered C-14-labeled tripalmitin emulsions. Science, **109:** 13, 1949.

Component Medical Societies

ANNE ARUNDEL COUNTY MEDICAL SOCIETY

GEORGE C. BASIL, M.D.

Journal Representative

Doctors Armstrong and Johnson were elected as members. Dr. Harry F. Klinefelter is conducting regular arthritic and rheumatic clinic at the Anne Arundel General Hospital.

The following officers elected for the year of 1953 are: President, Dr. J. Oliver Purvis; Vice-President, Dr. William J. French; Secretary-Treasurer, Dr. J. Howard Beard; Delegate, Dr. Bowie Grant; Board of Censors for 3 years, Dr. Donald Hooker; Alternate, Dr. William Thomas.

Baltimore City Medical Society and its Sections

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

By the time the May issue of the Journal is published the Medical and Chirurgical Faculty Ball will be a thing of the past and this first annual occurrence will have gone down in our history as the splendid affair that it was. The Woman's Auxiliary deserves praise for the initiative they have taken in reviving this affair. The difficulty will be living up to past performance.

* * * * *

The course in electrocardiography continues to have enthusiastic turnouts. The last scheduled date was changed because of conflict with the Annual Meeting. Due notice was given and the final lecture was not handicapped thereby. This series of meetings has been most interesting and enlightening. The different speakers and their uniformly complete grasp of subjects has made it unique.

* * * * *

The AMA broadcast on Saturdays from 8:30 to 9:00 p.m., should be followed with a good deal of interest by all. At this writing, it is too early to predict how they have been received.

* * * * *

The Constitution and By-Laws have been read, as required, in open meeting and will be received by every member in mimeographed form. President Wetherbee Fort urges careful study and consideration by every member so that possible difficulties can be ironed out well ahead of time. Things unforseeable can be anticipated by a broad, general overall approach to Society business. No matter how small a potential error is, you are urged to bring it and discuss it with members of this Committee.

* * * * *

The March meeting, "Seminar on Recent Advances in Radiological Studies of the Vascular System," was a step ahead. It brought together specialists in techniques few of us will ever hope to perform personally. The experts told the Society what is being, and what can be, done offering us new techniques and approaches to our difficult problems. Again the Program Committee is to be congratulated for, and encouraged in the tremendous reform it has made in our programs. Full attendance is witness that the Committee gives what the Society wants. Members of component societies are kept informed of the City Society program and are welcome to attend our meetings. We hope that our programs will be of interest to them and that they will be able to come, to join with us in our seminar and panel discussions on clinical medicine.

* * * * *

CANCER SECTION MEETING

ROBERT N. COOLEY, M.D.*

The Cancer Section of the Baltimore City Medical Society met at Top Cottage on the grounds of The

---

* Secretary, Cancer Section, Baltimore City Medical Society.

National Institutes of Health at Bethesda, Maryland on the evening of March 11th at 8 p.m.r D. Heller and the staff of the National Cancer Institute were the hosts for the evening. The program was under the charge of Dr. Mider.

The first paper of the evening was presented by Dr. Glenn Algire and was entitled, "Microscopic Studies on Tumor Histophysiology and Transparent Changes in Mice." Using an ingenious technique, Dr. Algire was able, by proper folding of loose skin on the back of the mouse, to obtain a small area which was thin enough to permit microscopic observation. This thinning of the skin is obtained by placing it between layers of plastic thus essentially it is enclosed in a chamber. After proper immobilization the skin and subcutaneous tissues can be clearly seen both under the conventional and phase microscope. Details of capillaries, arterioles, wandering cells, blood platelets and soforth are clearly seen. Also following the introduction of a heterogenous tumor subcutaneously, the activity of the tumor can be observed over a period of days. It has been found that new capillaries extend into the tumor within a very few days and that these capillaries have no vasomotor control. The effects on the tumor after a single exposure of a sizable dose of x-ray have also been observed. Even though the tumor was not destroyed by the irradiation the vascular bed within the tumor was so damaged that further cell proliferation was not possible.

Dr. Algire then showed a very striking movie made from the same sort of transparent chamber preparation in which the activities of the various tissue cells and elements could be observed directly. Observation and filming took place over many hours but by means of lag timing events occurring during this time could be viewed in a few minutes. Melanoma cells inoculated underneath the skin were surprisingly mobile and active. Also a method for measuring pressures in small vascular structures in the skin under direct vision was demonstrated. These techniques have been in use for only a few months and some of the pictures were produced within the last two or three weeks. Dr. Algire is planning to observe and film all phases of the growth of inoculated tumors and it would seem that this technique has opened up a major field of investigation of the details of tumor growth.

The second paper on the program was presented by Dr. Robert Smith and was entitled, "Surgical Approach to Head and Neck Cancer in Man." Dr. Smith briefly outlined the history of the treatment of head and neck cancer in man and told a number of interesting anecdotes. He cited that the emphasis in the treatment of these conditions during the past 30 years fluctuated and outlined the swing from surgery to radiation and back to surgery following the use of antibiotics, better anesthesia, better control of shock and etc. Surgical procedures are now much safer and are accompanied by a reduced mortality. Dr. Smith has operated upon a variety of carcinomas around the head and neck. Some of these have been of the hypopharynx, the larynx, the tonsil, tongue and floor of the mouth. Bilateral neck dissection has been used on a number of occasions. When the floor of the mouth was operated upon a portion of the mandible was resected almost as a routine procedure. Most of these operations have been done within the past year and there is no extended followup. Initial results, however, have been good and Dr. Smith is somewhat enthusiastic about these procedures; even if cure is not obtained palliative results seem to justify their use. Of course a more extended period of observation is necessary to evaluate the accomplishments of such methods of treatment.

Following the scientific portion of the program, there was a short social hour during which refreshments were served.

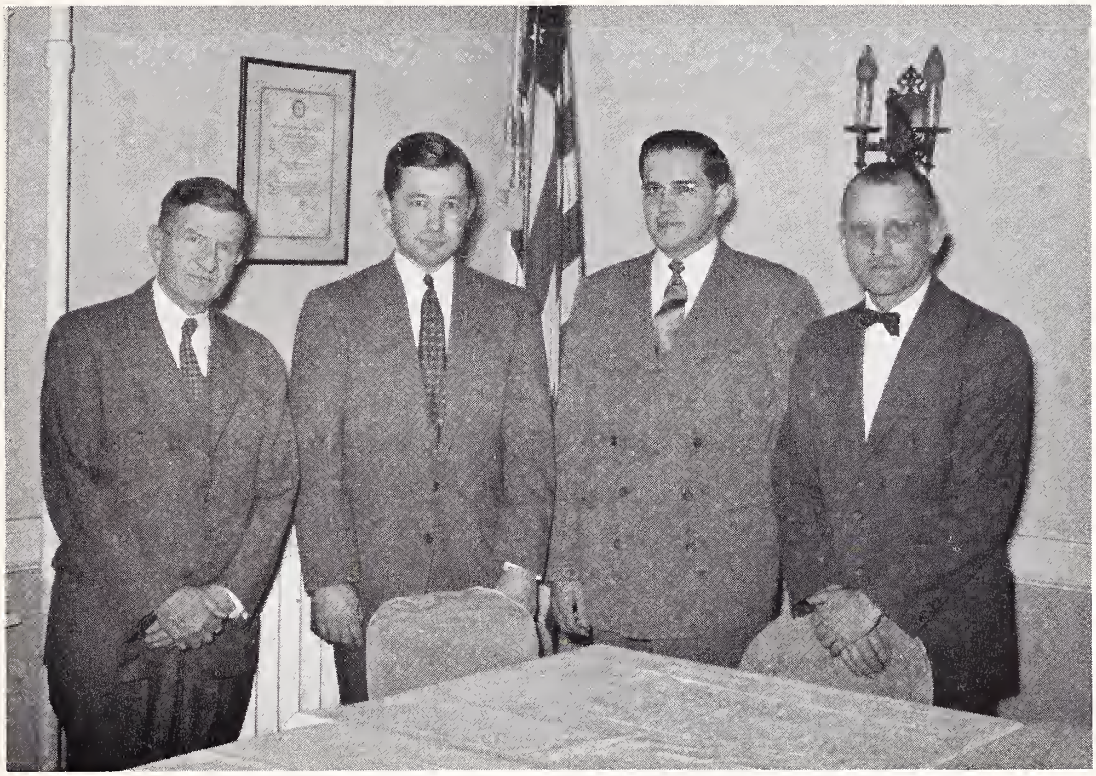
CAROLINE COUNTY MEDICAL SOCIETY

ROBERT WRIGHT, M.D.

Journal Representative

The following article appeared in the Denton Journal:

Dr. Samuel Asper, of the staff of Johns Hopkins Hospital, addressed the Upper Eastern Shore Medical Society at their banquet, on Thursday evening, January 22, at the Brick Hotel. Dr. Asper spoke on the treatment of thyroid diseases. Also shown with the speaker are: Dr. E. Paul Knotts, Denton, program chairman; Dr. Robert Wright, Greensboro, vice-president, and Dr. Edwin G. Riley, Denton, Caroline County Health Officer and secretary-treasurer of the society. Thirty-eight members from Caroline, Talbot, Queen Anne's and Kent Counties attended the meeting.



Dr. E. P. Knotts   Dr. Samuel Asper   Dr. Robert Wright   Dr. Edwin G. Riley

CARROLL COUNTY MEDICAL SOCIETY

W. H. FOARD, M.D.

Journal Representative

The Carroll County Medical Society met on Wednesday, January 21st in Westminster, Maryland at Hoffman Inn.

The guest speaker was Dr. James Karns of Baltimore. Dr. Karns gave a very interesting talk entitled "The Differential Diagnosis of Functional and Organic Heart Conditions."

The following were elected to be the new officers for the coming year: President, Dr. Merritt Robertson, New Windsor, Maryland; Vice-President, Dr. William Culwell, Mt. Airy, Maryland; Secretary-Treasurer, Dr. W. H. Foard, Manchester, Maryland; Delegate, Dr. M. C. Porterfield, Hampstead, Maryland; Alternate Delegate, Dr. R. H. Gardner, Sykesville, Maryland; Board of Censors, Dr. R. S. McVaugh, Taneytown, Maryland, Dr. Merritt Robertson, New Windsor, Maryland, Dr. James Marsh, Westminster, Maryland.

Dr. Charles R. Foutz of Westminster, Maryland celebrated his eightieth birthday on January 20, 1953. Tribute was paid to Dr. Foutz at an "open house" arranged by the doctor's four children.

Dr. Foutz has ministered to the medical needs of Carroll County from his home in Westminster for the past fifty-five years.

Aside from his medical practice, Dr. Foutz, has been keenly interested in community affairs.

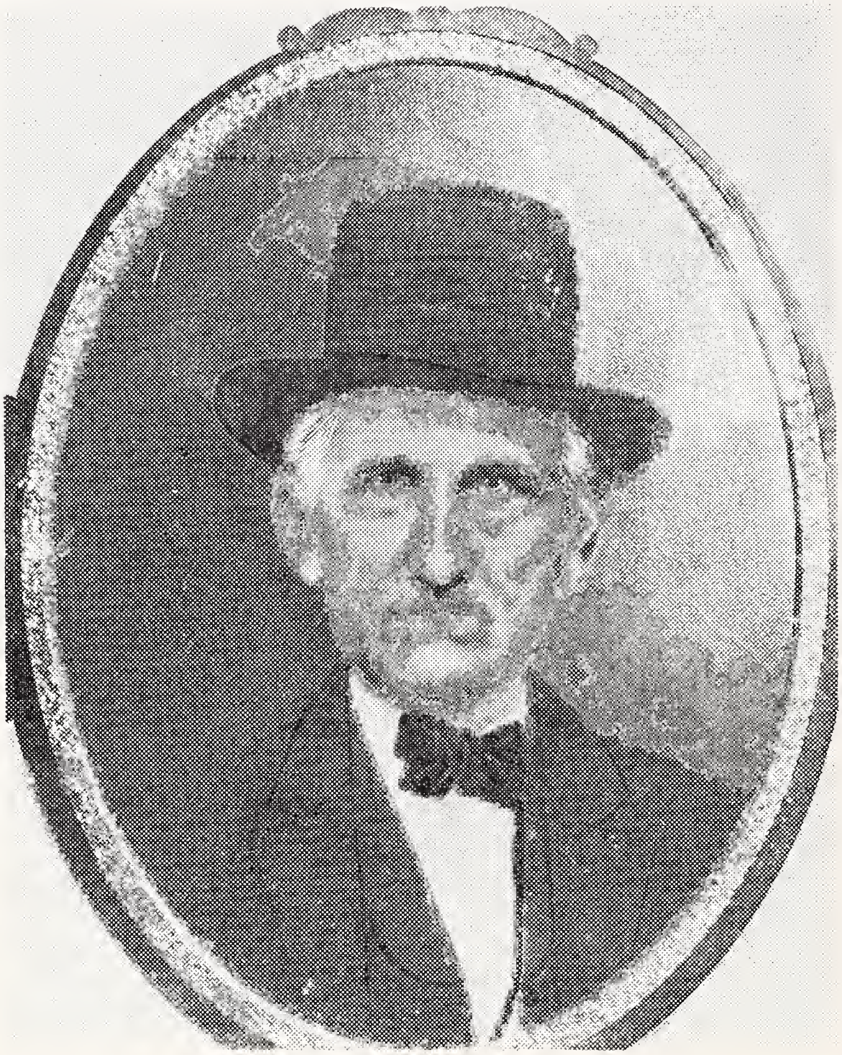
Dr. Foutz is noted for his energy and his zest and enthusiasm for living which have endeared him to old and young in all walks of life.

WASHINGTON COUNTY MEDICAL SOCIETY

O. D. SPRECHER, M.D.

Journal Representative

The following article appeared in The Daily Mail, Wednesday, January 21, 1953:



"WASHINGTON COUNTY MEDICAL SOCIETY RECEIVES PORTRAIT OF DR. HENRY ZELLER"

"Another portrait of a charter member of the Washington County Medical Society has been donated to the society to grace the walls of its home, Dorsey Hall.

"The daguerreotype of Dr. Henry Zeller of Williamsport, given to the group by Benjamin F. Snyder of Smithsburg was recently hung on the west wall of Dorsey Hall.

"Mr. Snyder, Dr. Zeller's nephew, recalled the doctor's habit of always wearing his hat. As you will note in the portrait, Dr. Zeller never sat for a picture without his high-crowned black hat. It was characteristic of the doctor to always place his hat beside him when in his office or his home dining room.

"Dr. Zeller was a fellow charter member of the Washington County Medical Society with the distinguished Dr. Frederick Dorsey, for whom the hall was named.

"In 1837, fresh from college, he settled in Williamsport as the village doctor and became known as one of the county's most skillful physicians.

"Many of Williamsport's older residents remember Dr. Zeller and may have been his patients.

"The doctor came from German ancestry, his great-grandfather having emigrated from Switzerland to settle in the wilderness of Washington County. The grandfather of Dr. Zeller was a member of the Maryland Line in the Revolution and was killed in the battle of Cowpens.

"Dr. Zeller's father, Otho, was born on the old Zeller place, near Hagerstown, which was known as the Red-Pump farm. On this farm was situated the Red-Pump Tavern—before the day of the railway known far and wide as the most inviting stopping place on the old road between Philadelphia and the West.

"Born August 17, 1810 in Washington County, six miles from Williamsport, Dr. Zeller was educated at the Hagerstown Academy. Required in those days were two years of reading medicine under a practicing physician, before entering college. Dr. Zeller studied with Dr. Dorsey and graduated in 1837 with the twelfth class of the Jefferson Medical School of Philadelphia.

"Being a country doctor entailed a working day of about 20 hours, long rides by horseback to his patients, sleepless nights and little pay.

"Besides being a charter member of the county society, Dr. Zeller also served on the County Board of Health organized on March 10, 1881. From District 8, the Downsville and Williamsport section, were other prominent men including: Dr. Lesher, Victor Cushwa, Henry Onderdonk and August Shorb."

* * * * *

TB SYMPOSIUM FOR GP'S IN SARANAC LAKE NEXT SUMMER

The Second Annual Tuberculosis Symposium for General Practitioners will be held in Saranac Lake, New York from July 13 through 17, 1953. It is approved by the American Academy of General Practice for 26 hours of formal credit for its members.

The Symposium is sponsored by the Saranac Lake Medical Society and the Adirondack Counties Chapter of the New York State Academy of General Practice. The registration fee is $40 for A. A. G. P. members and $50 for non-members. Registration is limited to 100 doctors.

Many physicians who attended last year's symposium brought their families to Saranac Lake. So that families might have use of the car to enjoy the many recreational facilities of the Adirondack Mountains, free bus transportation was provided for physicians from Saranac Lake to the various meeting places. This practice will be followed again this year.

These symposia are the result of many requests, during the last few years, from the General Practitioners for a postgraduate course on pulmonary tuberculosis designed for them and presented over a period short enough so that they might readily attend. The 1953 Symposium has been planned to meet those needs and to cover all important aspects of pulmonary tuberculosis from the General Practitioner's point of view. Many of the sessions are informal panel discussions with ample opportunities for questions from the audience.

The Symposium will be held in various sanatoria and laboratories in the Saranac Lake area. Morning sessions will be from 8:30 to 12:30 and afternoon sessions from 2:00 to 3:30 (Monday, Wednesday, and Thursday). There will be elective sessions on Tuesday and Friday afternoons. Physicians desiring to make patient rounds will have that opportunity each afternoon at 4:00. On Monday, July 13th there will be a dinner for physicians attending the course, their families and the faculty.

The speakers and panel members at the Tuberculosis Symposium will include physicians, surgeons and scientists from Saranac Lake and surrounding areas.

Complete information concerning this program can be obtained by writing: Richard P. Bellaire, M.D., Tuberculosis Symposium for General Practitioners, P. O. Box 707, Saranac Lake, New York.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

MEDICAL LIBRARIANS

Members attending a regional meeting of Medical Librarians of the Washington area, held in Baltimore on Saturday, April 11th, visited this library in the afternoon. After a cordial greeting from Dr. Louis Krause, Chairman of the Library Committee, tea was served, and members were given an opportunity to see the library and some of its treasures.

The morning meeting, held at the new Psychiatric Institute of the University of Maryland, included a symposium on "Weeding in Medical Libraries"; a talk on the future of medical education by Dr. H. B. Mulholland of the University of Virginia; and a talk by Lynn D. Poole, Director of Public Relations at Johns Hopkins University, and Producer of the "Science Review" program on television.

BOOKS ON OLD AGE

LOUIS KRAUSE, M.D.*

It is our wish to acquaint the readers of the Journal with some of the literary treasures that we have in our library. Each month, it is our plan to publish a list of the books that we have on various subjects. This month we are presenting the books on *Old Age*. You will note that many of them are very old, as a matter of fact, one or two are extremely rare gems. We hope that this might encourage more to read some of these books.

All of us have a stake in old age if we live long enough; and it is likewise our duty to prepare our patients while they are still in mid-life to grow old gracefully. It is in this spirit that the above list is presented.

It is to be recalled that our own American Doctor-Poet Oliver Wendell Holmes best expressed the psychology of old age in beautiful imagery in his poem, "The Last Leaf," which goes as follows:

> And I saw him once before,
> As he passed by the door and again
> The pavement stones resound
> As he totters o'er the ground with his cane.
>
> They say that in his prime,
> E're the pruning knife of time cut him down,
> Not a better man was found
> By the crier on his round through the town.
>
> But now he walks the streets
> And he looks at all he meets sad and wan,
> And he shakes his feeble head,
> That it seems as if he said, "They are gone."
>
> The mossy marbles rest
> On the lips that he has prest in their bloom,
> And the names he loved to hear
> Have been carved for many a year on the tomb.
>
> My grandmama has said
> Poor old lady, she is dead long ago
> That he had a Roman nose,
> And his cheek was like a rose in the snow.
>
> But now his nose is thin
> And it rests upon his chin like a staff.
> And a crook is in his back
> And a melancholy crack in his laugh.
>
> I know it is a sin
> For me to sit and grin at him here
> But the old three cornered hat,
> And the breeches, and all that, are so queer.

---

* Chairman, Library Committee, Medical and Chirurgical Faculty.

And if I should live to be
The last leaf upon the tree in the Spring,
Let them smile as I do now
At the old forsaken bough where I cling.

Finally it is to be remembered that we have within our own homes in the Bible one of the finest descriptions on old age in what I like to term a classical prose, an imagery: namely; the passage in Ecclesiastes or Qoheleth in the Hebrew, Chapter 12, Verses 1 to 7, beginning

> Remember now thy Creator in the days of thy youth, while the evil days come not, nor the years draw nigh, when thou shalt say, I have no pleasure in them;
>
> While the sun, or the light, or the moon, or the stars, be not darkened, nor the clouds return after the rain:
>
> In the day when the keepers of the house shall tremble, and the strong men shall bow themselves, and the grinders cease because they are few, and those that look out of the windows be darkened,
>
> And the doors shall be shut in the streets, when the sound of the grinding is low, and he shall rise up at the voice of the bird, and all the daughters of musick shall be brought low;
>
> Also when they shall be afraid of that which is high, and fears shall be in the way, and the almond tree shall flourish, and the grasshopper shall be a burden, and desire shall fail: because man goeth to his long home, and the mourners go about the streets:
>
> Or ever the silver cord be loosed, or the golden bowl be broken, or the pitcher be broken at the fountain, or the wheel broken at the cistern.
>
> Then shall the dust return to the earth as it was: and the spirit shall return unto God who gave it.

The following are some books on *Old Age* which are available in the Library:

Bennett, Sanford, Old age, its cause and prevention. New York, Dodd, Mead Co., 1927.

Boas, Ernst Philip, Treatment of the patient past fifty. Chicago, Year Book Publishers, Inc., 1941. Second edition, 1944.

Canstatt, C. F., Die krankheiten des höheren alters und ihre heilung. Erlangen Enke, 1839.

Carlisle, Sir Anthony, An essay on the disorders of old age. Philadelphia, E. Earle, 1819.

Charcot, J. M., Leçons sur les vieillards et les maladies chroniques. Paris, Delahaye, 1867.

Charcot, J. M., Clinical lectures on the diseases of old age. New York, W. Wood and Co., 1881.

Charcot, J. M., Maladies des vieillards, goutte et rhumatisme. Paris, Delahaye, 1890.

Child, Charles Manning, Senescence and rejuvenescence. Chicago, University of Chicago Press, 1915.

Cowdry, Edmund V., Problems of ageing; biological and medical aspects. Baltimore, Williams & Wilkins, 1939. 3rd. ed. 1952.

Durand-Fardel, C. L. M., Traité clinique et pratique des maladies des vieillards. Paris, G. Baillière, 1854.

Hall, G. S., Senescence: the last half of life. New York, Appleton, 1922.

Humphry, Sir G. M., Old age. Cambridge, Macmillan and Bowes, 1889.

Lipscomb, F. M., Diseases of old age. London, Baillière, Tindall and Cox, 1932.

Lorand, Arnold, Old age deferred. Second edition. Philadelphia, F. A. Davis Co., 1911. Fourth edition, 1914.

Metchnikoff, E. I. L., The prolongation of life. New York, Putnam's, 1908.

Nascher, Ignatz Leo, Geriatrics: the diseases of old age and their treatment. Philadelphia, Blakiston's Son and Co., 1914. Second edition, 1916.

Rauzier, G., Traité des maladies des vieillards. Paris, J. B. Baillière, 1909.

Rolleston, Sir H. D., Medical aspects of old age. London, Macmillan, 1932.

Schwalbe, Julius, Lehrbuch der greisenkrankheiten. Stuttgart Enke, 1909.

Smith, John, The pourtract of old age. London, Walter Kettilby, 1676.

Smith, Kline and French Laboratories, The clinical problems of advancing years. Philadelphia, Smith, Kline and French Laboratories, 1949. Second edition, 1951.

Stieglitz, Edward Julius, Geriatric medicine. Philadelphia, W. B. Saunders Co., 1943. Second edition, 1949.

Thewlis, Malford Wilcox, The care of the aged. St. Louis, C. V. Mosby Co., 1942.

U. S. Federal Security Agency, Fact book on aging. Washington, U. S. Government Printing Office, 1952.

U. S. Public Health Service, Illness and health services in an aging population. Wash., U. S. Government Printing Office, 1952.

U. S. Public Health Service, Mental health in later maturity. Washington, U. S. Government Printing Office, 1942.

Vecki, Victor G., Prevention of premature senility. Boston. Stratford Co., 1931.

Voronoff, Serge, Life: a study of the means of restoring vital energy and prolonging life. New York, Dutton, 1920.

Warthin, Aldred Scott, Old age, the major involution. New York, P. B. Hoeber, Inc., 1929.

State of Maryland Department of Health

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, April 3–30, 1953

																	DEATHS
	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCAL	MUMPS	POLIOMYELITIS, PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	Influenza and pneumonia
								Total, 4 weeks										
Local areas																		
Baltimore County	37	—	35	—	19	—	27	—	—	97	—	—	—	3	—	8	—	6
Anne Arundel	29	—	4	—	15	1	13	—	—	14	—	—	—	1	—	11	—	3
Howard	3	—	—	—	5	—	—	—	—	—	—	—	—	1	—	2	—	1
Harford	15	—	81	3	4	—	10	—	—	2	—	—	—	3	—	3	—	3
Carroll	11	—	—	5	1	—	6	—	—	—	—	—	2	3	—	1	—	2
Frederick	6	—	1	—	4	—	4	1*	—	4	—	—	—	4	—	1	—	1
Washington	3	—	—	—	4	—	3	—	—	2	1	—	—	8	—	4	—	2
Allegany	8	—	4	—	23	—	—	—	—	1	—	—	—	3	—	1	—	6
Garrett	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
Montgomery	49	—	26	3	33	—	37	—	—	3	—	—	—	6	—	—	—	4
Pr. George's	25	—	10	1	16	—	18	—	—	15	1	—	—	12	—	2	—	1
Calvert	—	—	—	—	—	—	—	—	—	2	—	—	—	1	—	1	—	—
Charles	—	—	—	1	1	—	2	—	—	1	—	—	—	1	—	—	—	—
Saint Mary's	—	—	—	4	—	1	—	—	—	2	1	—	—	3	—	1	—	—
Cecil	—	—	—	—	—	—	1	—	—	1	—	—	—	—	—	2	p-1	1
Kent	7	—	44	—	1	—	8	—	—	17	—	—	—	1	—	—	—	—
Queen Anne's	—	—	—	—	1	—	2	—	—	2	—	—	—	1	—	—	—	—
Caroline	1	—	1	—	—	—	—	—	—	—	—	—	—	—	3	—	—	—
Talbot	—	—	—	—	—	—	3	—	—	—	—	—	—	4	—	2	—	1
Dorchester	11	—	—	—	1	—	6	—	—	—	—	—	—	3	—	7	—	2
Wicomico	5	—	—	—	1	—	—	—	—	—	—	—	—	4	2	5	—	2
Worcester	—	—	—	1	—	—	—	—	—	—	—	—	—	4	1	1	—	—
Somerset	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	2	—	—
Total Counties	210	0	206	18	129	2	140	1	0	163	3	0	2	68	6	54	—	36
Baltimore City	287	1	156	5	118	6	201	0	0	296	1	0	2	97	9	538	—	22
State																		
April 3–30, 1953	497	1	362	23	247	8	341	1	0	459	4	0	4	165	15	592	—	58
Same period 1952	445	1	162	16	1474	15	138	0	0	110	0	1	16	199	15	506	—	72
5-year median	559	7	135	—	830	10	248	0	0	149	2	4	43	240	76	493	—	64
								Cumulative totals										
State																		
Year 1953 to date	2172	7	949	151	528	45	891	3	0	1576	8	2	71	798	55	2518	—	404
Same period 1952	1832	5	541	100	7705	48	544	6	0	577	7	9	66	902	52	2057	—	331
5-year median	2128	37	299	—	2280	43	910	2	0	639	7	18	268	905	359	2188	—	319

p = paratyphoid fever.
* = poliomyelitis case had 1952 onset.

BLUE CROSS AND BLUE SHIELD

YOUR DECISION AND BLUE CROSS

R. H. DABNEY*

Our most significant development over the past months has not been membership growth, although it has been satisfactory, but the necessity for the third rate increase in our history. The rate increase was effective March 1, 1953. The problems of such an increase—the additional work, the unhappy burden of explanation and justification could be postponed no longer. For the second consecutive year, Blue Cross had to dig into its contingency reserves to meet its obligations. Although people well know that the cost of almost everything has risen steadily over the past few years, many do not realize that our new rates reflect the accumulated increase in our payments to hospitals. If we were in a position to increase rates gradually, we're sure that the increase would have been accepted along with other higher costs.

The financial structure of every business in the country would be imperiled if inflation were allowed to go unchecked. Blue Cross is far more vulnerable to inflation than the traditional insurance company. We must buy hospital services at ever rising prices while commercial insurance companies can pay policyholders in greatly deflated dollars, leaving their members to foot the balance of the bill.

Some of the 89 Blue Cross Plans have attempted to meet the inflationary spiral by limiting the amount of service benefits and substituting a larger cash indemnity. We have avoided this, believing that comprehensive service is our most valuable asset and that the public needs a service policy now more than ever.

The March 1 rate increase, in addition to providing a more equitable distribution of costs among the various subscriber groups, will enable us to add to our contingency reserves during 1953 and help offset our mounting payments to hospitals. Obviously, the solution is a temporary one; the real solution lies in some other field.

As we have said before here, a major part of that solution lies with the doctors themselves. The major factors affecting the entire economies of our Plan are a matter of individual doctor determination. Just as the resources of Blue Cross-Blue Shield are made up of many thousands of payments from individual members, disbursements are made on the basis of individual decisions which together amount to millions of dollars. Reckon the additional annual cost to Blue Cross if:

1. One of every ten patients stayed an extra day in the hospital.
2. If 10% additional drugs were ordered for hospitalized members.
3. If each participating physician admitted only one additional Blue Cross member during the year.

These are decisions that the doctors must make. A few extra days of hospital care in isolated cases may seem to amount to very little; but when considering the volume of our admissions, the number of patient-days we must pay for each year, etc., such cases would greatly affect our total payments to hospitals.

The individual doctor's decisions are intricately tied in with the well-being and future of Blue Cross. Only through the doctors' careful consideration and sound judgment can we fulfill our purpose and continue to service the public as we have in the past.

---

* Executive Director, Maryland Hospital Service, Inc., Maryland Medical Service, Inc.

A LETTER RELATING TO "BLUE CROSS-BLUE SHIELD"

MARIUS P. JOHNSON, M.D.

222 Medical Arts Bldg.
Baltimore 1, Maryland

February 27, 1953

Dr. Osborn D. Christensen
124 E. Main Street
Salisbury, Maryland

Dear Dr. Christensen:

I was very happy to see your article in the February 1953 issue of the Maryland State Medical Journal entitled, "Blue Cross, Blue Shield; "Indemnity" or "Service." In the formative days of Maryland Blue Shield a questionnaire authorized by the Baltimore City Medical Society showed more than 80% of the returned inquiries favoring Indemnity type plan. The recommendations of the Baltimore City Society were not followed, as you know.

Subsequent expressions by the Blue Shield management have led us to expect repeated requests by the Board of Directors to increase the service level to include incomes up to $6000.000 per annum per family as the level for complete coverage. The fee schedule remaining at its present level would result in a definite reduction in the actual income to the physician with a series of attempts by him to augment through channels that would not be absolutely honest. Already the obstetrical group have been granted what amounts to the Indemnity type of insurance.

The pressure of Federal legislation and labor union leaders has motivated the majority of recommendations influencing the character of the present Blue Shield. On the face of this problem it looks harmless to the average physician, but it has an insidious drift which is right now becoming evident in the field of rent control, and like the landlord we will be, in self defense, rendering poorer services commensurate with our capital investment. Such an end result will only reactivate a renewed Federal pressure along a new line of attack. This time the doctor will not have as clean a bill as he at present enjoys.

I cannot endorse too heartily the principals of the Indemnity type of Blue Shield as being the best for both patient and doctor in the long run.

Most sincerely,
Marius P. Johnson

MPJ:ec/c

ANNUAL ASSEMBLY IN OTOLARYNGOLOGY

University of Illinois College of Medicine

The Department of Otolaryngology, University of Illinois College of Medicine, announces its Annual Assembly in Otolaryngology, divided into sections:

A. Basic Section, September 21 through 26, 1953, devoted to surgical anatomy and cadaver dissection of the head and neck, and histopathology of the ear, nose and throat, under the direction of Dr. M. F. Snitman.

B. Clinical Section, September 28 through October 3, 1953, consisting of lectures and panel discussions, with group participation of otolaryngological problems and current trends in medical and surgical management.

Registration will be limited. Application for attendance at one or both sections will be optional. For information write to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. CHARLES H. WILLIAMS, *Auxiliary Editor*

The Woman's Auxiliary to the Maryland State Medical Society sponsored a "Future Nurses' Day" on May 12th, Florence Nightingale's birthday, at the Faculty Building.

The Principals of High Schools in Maryland sent representatives from the Future Nurses' Clubs (if the school had one) and the senior girls who were definitely interested in nursing as a career to attend the convention. The following was the program:

First Convention

FUTURE NURSES OF MARYLAND

9 a.m. The History of Nursing—Marius P. Johnson, M.D.

9:30 a.m. Collegiate Nursing—Miss Florence Gipe, D.Ed., R.N., B.S., M.S., Dean, School of Nursing, University of Maryland.

10 a.m. Film—"This Way to Nursing," Courtesy American Medical Association.

11 a.m. Scholarship Information—Miss Anna Holmes, R.N., B.S., President, Maryland State Nurses Association, Lecturer Nurses Union Memorial Hospital.

11:30 a.m. The Role of a Nurse in a General Hospital—Mr. Harvey H. Weiss, Superintendent Sinai Hospital, Baltimore.

11:45 a.m. Practical Nursing—Miss Dorothy Volkman, R.N., B.S., M.S., Director Nurses, Director Practical Nurses, Baltimore City Hospital.

12 noon Lunch—provided by members of the Auxiliary who are Nurses.

1 p.m. Parade of Student Nurses in Uniform. Representing all the Nursing Schools in Baltimore.

1:45 p.m. Careers Open to Graduate Nurses—Miss Margaret Courtney, M.A., R.N., Nursing Arts Instructor, Johns Hopkins Hospital League of Nursing Education.

2:30 p.m. The Lighting of the Florence Nightingale Birthday Cake—A Student Nurse Speaks—Miss Carol Ann Wienefeld—Student Nurse, The Hospital for the Women of Maryland.

2:45 p.m. Film—"Your Doctor," Courtesy American Medical Association.

3 p.m. Adjournment.

The following letter, written March 24, 1953, was received by Mrs. Charles H. Williams from Mrs. Ralph Eusden, President of the Woman's Auxiliary to the American Medical Association:

"Thank you for the program of your Future Nurses Convention.

"In my opinion this is an outstanding event, insofar as I know the first one of its type. I shall appreciate it if you will give an account of this in your annual State report at the time of our National Convention. It would also be very fine if we had mimeographed programs as the one you sent me to give out at that time. May I congratulate you!"

Mrs. Williams also received a letter from Mr. Leo E. Brown, Director of the Department of Public Relations and assistant to the General Manager of the American Medical Association, which states:

"Congratulations on the excellent program you have developed for your first convention of the Future Nurses of Maryland. This is one of the finest public relations projects I have seen in a long time. You not only have cultivated a liaison with other allied groups, but your project is most worthwhile. Needless to say, we appreciate your interest in showing the film, "Your Doctor."

"I assume that you have made this information available to the AMA Woman's Auxiliary, because it seems to me that it would make an excellent report in the BULLETIN.

"Please don't forget to keep me informed of your activities, because such projects as yours are proof positive of the progress being made by medicine all over the country."

Letter to the Editor

April 10, 1953

George H. Yeager, M.D., Editor
Maryland State Medical Journal
1211 Cathedral Street
Baltimore 1, Maryland

Dear Dr. Yeager:

You probably are familiar with the attached two-page message which is scheduled for appearance in the May issue of the Maryland State Medical Journal.

Perhaps, however, you are not so familiar with the fact that for more than twenty-five years Parke, Davis & Company has been stressing, in various ways, "See Your Doctor" in its advertisements in leading national magazines reaching millions of homes each year.

The new series of magazine advertisements, starting this month and next, will have for its theme, "In the hands of the physician, you're in *good* hands," and we believe that members of the general public will, in many instances, be persuaded by it to do something about that long delayed visit to their doctors. Furthermore, we believe that they will be inclined to more readily accept the physician's advice as to treatment and procedure.

For your further information, and to give you an idea of what the new series will be like we are attaching advance proofs of the two first ads.* The uncaptioned one, showing three poses of a noncooperative individual, will appear in the April 25 number of the Saturday Evening Post and the May 17 issue of This Week Magazine. "Ever See a Telegram From Your Heart?" is scheduled for Saturday Evening Post, May 16; Time, May 25; Newsweek, June 8; This Week, June 21; Woman's Home Companion, June; and Good Housekeeping, July.

Don't you feel that many of your members will agree that such a series is truly "in the public interest"—and also in the best interests of the practice of medicine today?

Cordially and sincerely,

/s/ WALTER M. CHASE
Walter M. Chase
Assistant Director
Advertising and Public Relations
Parke, Davis & Company

---

* These "ads" may be seen at the Faculty office.

QUOTED FROM BULLETIN NO. 7-53, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC.

It is difficult to find any justification for burying health services in a Department where Social Security, with its large number of employees and its enormous disbursements, far overshadows the other functions of the proposed Department.

A Department of Welfare has long been the goal of the socialistic planners, most of whom are still in government protected by civil service even though the Republicans have "taken over." The socialists have looked upon a Department of Welfare as the ideal operational set-up to control a program of nationalized medicine—socialized medicine. These socialistic planners in FSA will be given an assist to their infamous scheme through added prestige and influence to be gained from departmental status.

DIRECTORY

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

March 31, 1952–March 31, 1953

LIST OF PRESIDENTS—1799–1953

1799–1801—Upton Scott.
1801–1815—Philip Thomas.
1815–1820—Ennals Martin.
1820–1826—Robert Moore.
1826–1836—Robert Goldsborough.
1836–1841—Maxwell McDowell.
1841–1848—Joel Hopkins.
1848–1849—Richard Sprigg Steuart.
1849–1850—Peregrine Wroth.
1850–1851—Richard Sprigg Steuart.
1851–1852—William W. Handy.
1852–1853—Michael S. Baer.
1853–1854—John L. Yeates.
1854–1855—John Fonerden.
1855–1856—Jacob S. Baer.
1856–1857—Christopher C. Cox.
1857–1858—Joshua I. Cohen.
1858–1859—Joel Hopkins.
1859–1870—Geo. C. M. Roberts.
1870—John R. W. Dunbar.
1870–1872—Nathan R. Smith.
1872–1873—P. C. Williams.
1873–1874—Charles H. Ohr.
1874–1875—Henry M. Wilson.
1875–1876—John F. Monmonier.
1876–1877—Christopher Johnston.
1877–1878—Abram B. Arnold.
1878–1879—Samuel P. Smith.
1879–1880—Samuel C. Chew.
1880–1881—H. P. C. Wilson.
1881–1882—Frank Donaldson.
1882–1883—William M. Kemp.
1883–1884—Richard McSherry.
1884–1885—Thomas S. Latimer.
1885–1886—John R. Quinan.
1886–1887—George W. Miltenberger.
1887–1888—I. Edmondson Atkinson.
1888–1889—John Morris.
1889–1890—Aaron Friedenwald.
1890–1891—Thomas A. Ashby.
1891–1892—William H. Welch.
1892–1893—L. McLane Tiffany.
1893–1894—George H. Rohé.
1894–1895—Robert W. Johnson.
1895—J. Edwin Michael.
1895–1896—Charles G. Hill.
1896–1897—William Osler.
1897–1898—Charles M. Ellis.
1898–1899—Samuel C. Chew.
1899–1900—Clotworthy Birnie.
1900–1901—Samuel Theobald.
1901–1902—J. McPherson Scott.
1902–1903—William T. Howard.
1903–1904—Eugene F. Cordell.
1904–1905—Edward N. Brush.
1905–1906—Samuel T. Earle, Jr.
1906–1907—Hiram Woods.
1907–1908—Charles O'Donovan.
1908–1909—Brice W. Goldsborough.
1909–1910—G. Milton Linthicum.
1910–1911—Franklin B. Smith.
1912—Hugh H. Young.
1913—Archibald C. Harrison.
1914—Randolph Winslow.
1915—J. W. Humrichouse.
1916—J. Whitridge Williams.
1917—Guy Steele.
1918—William S. Halsted.
1919—John Ruhräh.
1920—James E. Deets.
1921—William S. Gardner.
1922—Arthur H. Hawkins.
1923—Herbert Harlan (Jan.–Aug.). Harry Friedenwald (Aug.–Dec.).
1924—Philip Briscoe.
1925—Lewellys F. Barker.
1926—Thomas B. Johnson, Deceased December 25, 1925.
1926—Josiah S. Bowen.
1927—Thomas S. Cullen.
1928—Peregrine Wroth, Jr.
1929—Alexius McGlannan.
1930—Henry M. Fitzhugh.
1931—J. M. H. Rowland.
1932—Eldridge E. Wolff.
1933—J. Albert Chatard.
1934—George O. Sharrett.
1935—J. M. T. Finney, Sr.
1936—Frederick D. Chappelear.
1937—Arthur M. Shipley.
1938—Frank B. Hines.
1939—Dean Lewis: Acting President, Victor F. Cullen.
1940—Edward P. Thomas.
1941—Harvey B. Stone.
1942—R. Lee Hall.
1943—Charles R. Austrian.
1944—Jacob W. Bird.
1945—Carroll Lockard.
1946—Thomas R. Chambers.
1947—William T. Hammond.
1948—Charles W. Maxson.
1949—W. Houston Toulson.
1950—A. Austin Pearre.
1951—Walter Dent Wise.
1952—Alan M. Chesney.
1953—Maurice C. Pincoffs.

LIST OF VICE-PRESIDENTS

1799–1848—(Unknown.)
1848–1849—John Readel, Jacob Baer, P. Wroth.
1850–1851—Joel Hopkins, P. Wroth, Jacob Fisher.
1851–1853—(Unknown.)
1853–1854—John Fonerden, Albert Ritchie, P. Wroth.
1854–1855—Geo. C. M. Roberts, Samuel P. Smith, Joel Hopkins.
1855–1856—George C. M. Roberts, G. W. Miltenberger, M. Diffenderffer.
1856–1857—P. Wroth, Wm. H. Davis, Samuel Smith.
1857–1858—William Waters, Frederick Dorsey, Joel Hopkins.
1858–1859—Samuel Chew, Stephen N. C. White, Samuel K. Handy.
1859–1863—John R. W. Dunbar, Samuel Chew, Wm. M. Kemp.
1863–1871—John R. W. Dunbar, Wm. M. Kemp, John C. Hopkins.
1871–1872—C. H. Ohr, Edward Warren, Richard McSherry.
1872–1873—(Unknown.)
1873–1874—Samuel Chew, H. M. Wilson, A. B. Arnold.
1874–1875—Francis T. Miles, James A. Steuart, D. A. O'Donnell.
1875–1876—Christopher Johnston, A. B. Arnold, J. C. Thomas.
1876–1877—P. C. Williams, James A. Steuart, Francis T. Miles.
1877–1878—S. C. Chew, F. E. Chatard, Charles H. Jones.
1878–1879—James C. Thomas, L. McLane Tiffany.

---

* Transactions, 1953.

1879–1880—H. P. C. Wilson, James A. Steuart.
1880–1881—L. McLane Tiffany, G. Ellis Porter.
1881–1882—A. H. Bayly, I. E. Atkinson.
1882–1883—Thomas S. Latimer, Richard McSherry.
1883–1884—W. Stump Forward, J. S. Lynch.
1884–1885—John R. Quinan, I. E. Atkinson.
1885–1886—E. C. Baldwin, J. E. Michael.
1886–1887—Thomas Opie, Richard Gundry.
1887–1888—Charles H. Jones, James Carey Thomas.
1888–1889—J. E. Michael, Thomas P. Evans.
1889–1890—T. A. Ashby, C. G. W. Macgill.
1890–1891—Geo. H. Rohé, J. McPherson Scott.
1891–1892—J. W. Humrichouse, David Streett.
1892–1893—J. W. Downey, J. W. Chambers.
1893–1894—John D. Blake, John S. Fulton.
1894–1895—Charles H. Jones, W. M. Nihiser.
1895–1896—Charles G. Hill, Clotworthy Birnie.
1896–1897—Wilmer Brinton, Randolph Winslow.
1897–1898—W. F. A. Kemp, George J. Preston.
1898–1899—Mary Sherwood, J. McPherson Scott.
1899–1900—Samuel Theobald, David Streett.
1900–1901—Samuel T. Earle, Jr., J. B. R. Purnell.
1901–1902—Harry Friedenwald, B. W. Goldsborough.
1902–1903—Samuel T. Earle, Jr., Wilmer Brinton.
1903–1904—Franklin B. Smith, James M. Craighill.
1904–1905—Samuel T. Earle, Jr., D. C. R. Miller, Julius A. Johnson.
1905–1906—Charles O'Donovan, Thomas M. Chaney, Joseph B. Seth.
1906–1907—William T. Watson, Philip Briscoe, William F. Hines.
1907–1908—Roger Brooke, Henry L. P. Naylor, George Dobbin.
1908–1909—Philip Briscoe, William L. Smith, G. Milton Linthicum.
1909–1910—Philip Briscoe, A. P. Herring, Compton Riely.
1910–1911—J. Staige Davis, H. B. Gantt, Timothy Griffith.
1912—J. L. Riley, D. E. Stone, J. A. Chatard.
1913—J. Staige Davis, C. F. Davison, E. B. Claybrook.
1914—C. R. Winterson, A. L. Franklin, Gordon Wilson.
1915—A. McGlannan, J. E. Deets, R. Lee Hall.
1916—L. C. Carrico, M. D. Norris, J. A. Chatard.
1917—D. E. Stone, A. H. Hawkins, J. M. H. Rowland.
1918—Julius Friedenwald, J. E. Deets, J. McF. Dick.
1919—J. McF. Bergland, Philip Briscoe, J. E. Deets.
1920—T. R. Boggs, A. M. Shipley, Eugene Jones.
1921—J. H. M. Knox, Jr., A. H. Hawkins, C. E. Davidson.
1922—Harry Friedenwald, W. R. White, J. S. Bowen.
1923—J. M. H. Rowland, Harry Friedenwald, Peregrine Wroth, Jr.
1924—C. Urban Smith, J. Percy Wade, E. E. Wolff.
1925—J. S. Bowen, T. B. Johnson, J. McF. Dick.
1926—Standish McCleary, G. Roger Myers, S. A. Nichols.
1927—Standish McCleary, John L. Riley, Frank S. Keating.
1928—J. Albert Chatard, F. B. Hines, R. T. Miller, Jr.
1929—Henry M. Fitzhugh, Robert P. Bay, Thomas R. Boggs.
1930—F. D. Chappelear, W. T. Hammond, F. B. Hines.
1931—W. D. Campbell, H. M. Lankford, Charles Maxson.
1932—W. T. Hammond, John T. King, Jr., Lewis K. Woodward.
1933—S. A. Nichols, E. H. Hutchins, W. S. Seymour.
1934—G. C. Lockard, W. R. White, J. L. Riley.
1935—J. McF. Dick, Louis Hamman, V. D. Miller.
1936—Harvey G. Beck, Norman S. Dudley, Jesse O. Purvis.
1937—Harvey B. Stone, W. A. Gracie, R. Lee Hall.
1938—Frank S. Lynn, Richard C. Dodson, Everard Briscoe.
1939—Victor F. Cullen, Frederic V. Beitler, William D. Noble.
1940—Edward P. Smith, H. A. Cantwell, Charles L. Owens.
1941—Guy L. Hunner, Charles R. Foutz, R. Lee Hall.
1942—Maurice C. Pincoffs, Wm. F. Williams, Jacob W. Bird.
1943—Charles Reid Edwards, A. Austin Pearre, J. Oliver Purvis.
1944—Alan M. Chesney, William D. Campbell, Hugh R. Spencer.
1945—William N. Palmer, Harry R. Slack, Armfield F. Van Bibber.
1946—William D. Noble, Grant E. Ward, John S. Green, Jr.
1947—Huntington Williams, Frank M. Wilson, J. Herbert Bates.
1948—William Neill, Jr., Baltimore; Samuel E. Enfield, Cumberland; F. Seton Waesche, Snow Hill.
1949—Amos R. Koontz, Baltimore; O. H. Binkley, Hagerstown; P. E. Cox, Easton.
1950—I. Ridgeway Trimble, Baltimore; Vincent H. Davis, Chesapeake City; Thomas K. Galvin, Baltimore.
1951—Samuel McLanahan, Baltimore; Frank D. Worthington, Frederick; Frank W. Smith, Chestertown.
1952—Frank J. Geraghty, Baltimore; W. A. Gracie, Cumberland; Deceased 12-28-51; William F. Williams, Cumberland; R. Carmichael Tilghman, Baltimore.
1953—George O. Eaton, Baltimore; Osborne D. Christensen, Salisbury; William F. Williams, Cumberland.

ACTIVE MEMBERS OF COMPONENT SOCIETIES, 1953*

Allegany-Garrett County

Alvarez, Joseph, 101 Third Street, Oakland, Md.
Ballin, R. W., 62 Greene Street, Cumberland, Md.
Baumgartner, E. I., Oakland, Md.
Benjamin, Gilbert W., Hillen Station Baltimore 2, Md.
Brings, Elizabeth, La Vale, Md.

---

* Unless otherwise designated.

Brings, Lewis, 57 Greene St., Cumberland, Md.
Cawley, Frank, Memorial Hospital, Cumberland, Md.
Cooper, Leonard S., Medical Building, Cumberland, Md.
Cowherd, J. Kile, 41 Greene Street, Cumberland, Md.
Daugherty, Leslie E., 7 Washington Street, Cumberland, Md.
Davis, Frank U., 22 Washington Street, Cumberland, Md.
Davis, John B., 2 Broadway, Frostburg, Md.
Deming, Herbert V., 125 Bedford Street, Cumberland, Md.
Diehl, H. C., Frostburg, Maryland
Dunne, Thomas B., Office of Surgeon General, Dept. of Army, Preventive Medicine Division, Washington 25, D. C.
Durrett, Clay Earl, 236 Virginia Avenue, Cumberland, Md.
Dyer, John, 3510th Medical Group, Randolph Field Base, Texas
Eliason, H. W., 126 Union St., Cumberland, Md.
Enfield, Samuel E., 116 S. Liberty Street, Cumberland, Md.
Faw, Wylie M., Jr., 5 Washington Street, Cumberland, Md.
Fazenbaker, A. J., Westernport, Maryland
Feaster, James, Oakland, Md.
Frantz, Winter R., City Hall, Cumberland, Md.
Frye, Paul, 110 Mt. Lebanon Dr., Wheeling, W. Va.
Gardner, Charlotte B., 126 Columbia Avenue, Cumberland, Md.
Gattens, Wilbur E., Frostburg, Md.
Grove, Donald B., Medical Building, Cumberland, Md.
Hallinan, James P., 300 Decatur Street, Cumberland, Md.
Harrat, Frank T., 59 E. Main Street, Frostburg, Md.
*Hawkins, Arthur G., Cumberland, Md.
Hodges, Wyllys R., Jr., 122 Centre Street, Cumberland, Md.
Jacobson, Samuel M., Pershing St., Cumberland, Md.
Johnson, James T., Jr., 206 Washington Street, Cumberland, Md.
Jones, Arthur F., 329 Cumberland Ave., Cumberland, Md.
Jones, Emmett Lee, Jr., 50 Pershing Street, Cumberland, Md.
Kroll, Mark, 110 S. Centre Street, Cumberland, Md.
Ley, Leo H., Jr., Cumberland, Md.
Lusby, Thomas F., II, Oakland, Md.
McLane, W. Oliver, Jr., Frostburg, Md.
McLean, James E., 49 Greene Street, Cumberland, Md.
Mance, A. E., Oakland, Md.
Mathews, L. B., 49 Greene Street, Cumberland, Md.
*Matthai, Jacob H., Cumberland, Md.
Mirkin, Abraham J., 115 S. Center Street, Cumberland, Md.
Moseley, W. E., Mt. Savage, Md.
Mozzer, Alexander J., Western Md. Railroad, Cumberland, Md.
Murray, Francis Alan C., 41 Greene Street, Cumberland, Md.
Myers, L. R., 122 S. Centre St., Cumberland, Md.
Owens, Charles L., 305 Washington Street, Cumberland, Md.
Ranson, Leland B., 41 Greene Street Cumberland, Md.
Rathbone, R. Rhett, 122 S. Centre Street, Cumberland, Md.
Rees, David T., 404 Decatur Street, Cumberland, Md.
Reeves, J. Norman, Westernport, Md.
Reeves, Raymond W., Westernport, Md.
Reiter, Ralph A., 112 Bedford St., Cumberland, Md.
Richards, George J., Lonaconing, Md.
Robinson, H. Thomas, Jr., 132 S. Liberty Street, Cumberland, Md.
Roth, Oliver Ralph, 427 Goethe Street, Cumberland, Md.
Rothstein, Martin M., Frostburg, Maryland
Rozum, John Karol, 305 Decatur Street, Cumberland, Md.
Schindler, Blaine M., 41 Greene Street, Cumberland, Md.
Simons, George, 128 Union Street, Cumberland, Md.
Skitarelic, Benedict, Memorial Hospital, Cumberland, Md.
Stegmaier, James G., 122 S. Centre Street, Cumberland, Md.
* Taylor, E. Don, Lonaconing, Md.
Tepfer, Milton, Friendsville, Md.
Tolson, Howard L., Medical Building, Cumberland, Md.
Trevaskis, R. W., 220 Baltimore Avenue, Cumberland, Md.
Trevaskis, R. W., Jr., 220 Baltimore Avenue, Cumberland, Md.
Van Ormer, W. Alfred, 531 Louisiana Avenue, Cumberland, Md.
Walters, Hilda Jane, 48 Broadway, Frostburg, Md.
Weisman, Saville G., 59 Greene Street, Cumberland, Md.
Wenzel, J. W., Oak and Eighth Streets, Oakland, Md.
Whitworth, Fuller B., 123 Bedford Street, Cumberland, Md.
Williams, Richard Jones, 122 S. Centre Street, Cumberland, Md.
Williams, William F., 122 S. Centre Street, Cumberland, Md.
Wolferman, Adolf, Frostburg, Maryland
Zimmerman, Charles Conrad, 105 S. Centre Street, Cumberland, Md.

Anne Arundel County

Alexander, John G., Crain Highway and 2nd Avenue, Glen Burnie, Md.
Allen, Aris Tee, 10 Carroll St., Annapolis, Md.
Allen, Faye W., 10 Carroll Street, Annapolis, Md.
Anderson, Albert L., Southgate Ave., Annapolis, Maryland
Armstrong, Robert, 71 Franklin St., Annapolis, Md.
Ball, Charles L., Jr., Linthicum Heights, Md.
Basil, George C., 59 Franklin Street, Annapolis, Md.
Beard, J. Howard, Box 626, Annapolis, Md.
Beck, Edward S., 41 Southgate Ave., Annapolis, Md.
Benedict, Ludwig, Crownsville, Md.
Borssuck, Samuel, Amos Garrett Boulevard, Annapolis, Md.
Briscoe, Philip, 212 Prince George Street, Annapolis, Md.
Christhilf, Stuart, Jr., 69 Franklin Street, Annapolis, Md.
* Claffy, John M., Annapolis, Md.
Clark, John A., House of Correction, Jessups, Md.
Faubert, Gustav H., 5 First Avenue, S. E., Glen Burnie, Md.
Field, Edward G., 1 Crain Highway, Glen Burnie, Md.
French, William J., 116 Gloucester St., Annapolis, Md.
Gaalaas, A., Green Gables, Box 80, Pasadena, Md.
Gould, Vincent, Mayo, Md.
Grant, Bowie Lynn, Shadyside, Md.

---

* Deceased.

Grimaldi, Pasquale John, 4609 Governor Ritchie Highway, Baltimore 25, Md.
Grossi, Igino, 201 N. W. Baltimore, Annapolis Blvd., Glen Burnie, Md.
Hadley, Henry G., 1252 Sixth St., Wash. 4, D. C.
Hooker, Donald, 90 Cathedral Street, Annapolis, Md.
Hunt, Barbara, Ewell, Md.
Johnson, Theodore H., 40 Northwest St., Annapolis, Md.
Jones, Bobby L., 5 Central Avenue, S.W., Glen Burnie, Md.
Klawans, Maurice F., Southgate Avenue, Annapolis, Md.
Klinger, Stephen, Crownsville State Hospital, Crownsville, Md.
Linhardt, Elmer G., 3 Chesapeake Ave., Eastport, Md.
Linthicum, Charles, Linthicum Heights, Md.
Loebl, Julius, 204 Crain Highway, South Glen Burnie, Md.
MacDonald, Charles R., 7 Central Avenue, Glen Burnie, Md.
McLaughlin, Randall, Mountain Road, Pasadena, Md.
Manuzak, Hubert F., 901 Edgerly Road, Harundale, Glen Burnie, Md.
Martin, James R., 185 Prince George Street, Annapolis, Md.
Morgenstern, Jacob, Crownsville State Hospital, Crownsville, Md.
Ochs, Irving L., 51 Southgate Avenue, Annapolis, Md.
Purvis, Jesse Oliver, 40 Franklin Street, Annapolis, Md.
Richardson, R. L., 110 Clay Street, Annapolis, Md.
Rodler, Edith, 42 State Circle, Annapolis, Md.
Russell, John T., Eastport, Md.
Shipley, Frank M., 63 College Avenue, Annapolis, Md.
Skerritt, Edward G., Millersville, Md.
Sosnowski, A. R., 4016 Ritchie Highway, Baltimore 25, Md.
Thomas, William Nathaniel, Jr., 71 Franklin Street, Annapolis, Md.
Trettin, G. Douglas, Severna Park, Md.
Trevett, Elizabeth Peabody, ℅ American Embassy, Bagdad, Iraq.
Waite, Merton T., 56 Southgate Ave., Annapolis, Md.
Walker, Stuart H., Carvel Hall, Annapolis, Md.
Weitzman, Frances E., 130 Lafayette Avenue, Annapolis, Md.
Welch, Robert S. G., Annapolis, Md.
Wilkins, Jesse Lee, 232 Prince George Street, Annapolis, Md.
Willoughby, M. K., Ritchie Highway at Sand Rock Bldg., Severna Park, Md.
Wilson, Emily H., Harwood, Md.
Wright, J. LeRoy, Cockeysville, Md.
Zangara, H. F., 307 Newburg Avenue, Baltimore 28, Md.

Baltimore City

Active Members

Abbott, Thomas G., 4509 Liberty Heights Avenue—7
Abercrombie, Anna S., 3524 Greenmount Avenue—18
Abercrombie, Ronald T., 3908 N. Charles Street—18
Abeshouse, Benjamin S., 100 W. Monument Street—1
Abramovitz, Leonard J., 2519 Talbot Road—16
Abrams, Michael A., 1820 Eutaw Place—17
Abrams, Robert Calvin, 1820 Eutaw Place—17
Acton, Conrad, 1208 St. Paul Street—2
Acton, Elizabeth, 700 Cathedral Street—1
Adams, Frederick K., 1222 N. Caroline Street—13
Adams, Maurice L., 238 N. Cary Street—23
Adams, Nicholas Floyd, Jr., 1118 St. Paul Street—2
Adams, Thurston R., University Hospital—1
Akman, Leonard Carl, 803 Cathedral Street—1
Alagia, Damian P., 305 Frederick Avenue—28
Alecce, A. Andrew, 3330 E. Baltimore Street—24
Alessi, Edward J., 6217 Harford Road—14
Alessi, Silvio A., 6217 Harford Road—14
Allan, Warde B., 6 E. Eager Street—2
Alvarez de Chaudens, Jose A., 2006 Deering Avenue—30
Anderson, Andrew R., 700 Cathedral Street—1
Anderson, George Woodrow, Johns Hopkins Hospital—5
Anderson, Townsend W., 01726034 Hdq. 4th Inf. Div., APO 39, ℅ P.M., New York, N. Y.
Anderson, Walter A., 3001 Shannon Drive—13
Andrus, E. Cowles, 24 E. Eager Street—2
Ankudas, Stanley, 3704 Hillsdale Rd.—7
Appelfeld, Willard D., 2511 Reisterstown Road—17
Ardinger, Joseph Stanley, Jr., 1230 Augusta Avenue—29
Arnold, James G., 11 E. Chase Street—2
Artigiani, Philibert, 2942 E. Fayette Street—24
Ascher, Eduard, The Latrobe Apartments—2
Ashman, Harry, 3700 Garrison Blvd.—15
Ashman, Leon, 1201 Poplar Grove Street—16
Ashworth, John William, 1129 St. Paul Street—2
Askin, John A., 1406 Eutaw Place—17
Asper, Samuel P., Johns Hopkins Hospital—5
Athey, H. B., 2504 St. Paul Street—18
Aubrey, John Forsythe, 2583 Bayshore Drive, Miami, Fla.
Austrian, Charles R., 1417 Eutaw Place—17
Ayd, Frank J., 2005 E. Monument Street—5
Ayd, Frank J., Jr., 6231 York Road—12
Babb, Dudley C., 1100 N. Charles Street—1
Bacharach, David, 4500 Bonner Road—16
Bachman, Leonard, U. S. Naval Hospital, Chelsea, Mass.
Baetjer, Walter A., 1101 St. Paul Street—2
Baggott, Bartus T., 3812 Greenmount Avenue—18
Bagley, Cecil H., The Latrobe Apts.—2
Bagley, Charles, Jr., The Latrobe Apts.—2

Bagley, Charles, III, University Hospital—1
Bahnson, Henry T., Johns Hopkins Hospital—5
Baker, Benjamin M., Jr., 9 E. Chase Street—2
Baker, Frank William, Jr., A02240719, 5005th Hospital, APO 949 ℅ P.M., Seattle, Wash.
Baldwin, Ruth Workman, University Hospital—1
Balfour, Charles Edward, 1103 St. Paul Street—2
* Ballard, Edwin Kemp, 1622 Mt. Royal Avenue—17
Ballard, Margaret B., Medical Arts Bldg.—1
Ballich, Nicholas L., 11 E. Chase Street—2
Ballina, Jones B., 1036 N. Calvert Street—2
*Bampfield, F. J., 1543 Northern Parkway—12
Banfield, Gilbert L., 722 N. Fulton Avenue—17
Barnaby, John W., Jr., 1531 E. North Avenue—13
Barnes, Thomas G., University Hospital—1
Barnett, Donald J., X-ray Dept., University Hospital—1
Barranco, S. H., 436 E. Fort Avenue—30
Battaglia, D. Thomas, 5829 Belair Road—6
Bauer, Robert E., 5711 Nasco Place—12
Baum, Max, 1501 N. Milton Avenue—13
Bawden, George A., Medical Arts Building—1
Bayer, Ira E., 11 E. Chase Street—2
Baylin, Morris J., 2040 Eutaw Place—17
Baylor, John W., 22 E. Gay Street, Westchester, Pa.
Baylus, Herman H., 1600 Wilkens Avenue—23
Baylus, Meyer Milby, 2216 Eutaw Place—17
Beacham, Edmund George, 1721 E. 33rd Street—18
Beck, Harry McBrine, 120 Midhurst Road—12
* Beck, Harvey G., 100 E. 23rd Street—18
Beck, Nathaniel M., 2818 St. Paul Street—18
Beissinger, Heinz F., 5201 Pleasant Street—7
Benesuns, Joseph G., 110 E. Lombard Street—2
Benet, Eben Thorpe, Hermit Thrush, Cape Elizabeth, Me.
Bennett, George E., 4 E. Madison Street—2
Benson, Carl F., 5111 York Road—12
Benson, John Fisher, 740 Whittington Avenue, Hot Springs, Ark.
Berdiansky, Benjamin, 5004 Ritchie Highway—25
Bereston, Eugene S., 2406 Eutaw Place—17
Bergland, John McF., 1014 St. Paul Street—2
Berman, Edgar F., 803 Cathedral Street—1
Bernheim, Bertram M., 2424 Eutaw Place—17
Bernstein, Alan, 1109 N. Calvert Street—2
Berry, Robert Zinn, Medical Arts Building—1
Bestebreurtje, Annie M., University Hospital—1
Betz, Barbara J., 1503 Bolton Street—17
Biehl, Harold Paul, 11 E. Chase Street—2
* Billups, Gaius W., 504 Murdock Road—12
Bindeman, William Wylie, U. S. Army Hospital, Ft. Lawton, Wash.
Bing, James F., 609 Cathedral St.—1
Bird, Joseph Gordon, Northwood Professional Center, 1532 Havenwood Road—18
Bishop, G. W., Sheridan Avenue and York Road—12
Bix, Hans, 2516 Linden Avenue—17
Blair, Emil, Duke University, Durham, N. C.
* Blake, Herbert C., Medical Arts Bldg.—1
Blalock, Alfred, Johns Hopkins Hospital—5
Blazek, Charles Joseph, 101 E. Biddle Street—2
Blechman, A. Joel, 3426 Bank Street—24
Block, Walter P., 509 Drury Lane—29
Blum, Joseph S., 1115 N. Calvert Street—2
Blum, Louis V., 2310 Eutaw Place—17
Bodenheimer, Ernst, 1212 Eutaw Place—17
Bogorad, Daniel E., 1905 W. Baltimore Street—23
Bohlman, Harold R., Medical Arts Bldg.—1
Bokhair, Lee, Maryland General Hospital—1
Bongardt, Henry F., 201 W. Madison Street—1
Borden, Jesse N., 1109 N. Calvert Street—2
Borden, Melvin N., 5000 Old Frederick Road—29
Bordley, James, Jr., 330 N. Charles Street—1
Bordley, John Earle, Johns Hopkins Hospital—5
Borges, Francis Joseph, 2528 Maryland Avenue—18
Borkovic, George William, 5115 Old Frederick Road—29
Borkovich, Katherine H., 11 E. Chase Street—2
Boslow, Harold Meyer, 700 Cathedral Street—1
Boss, M. Theodore, Medical Arts Bldg.—1
Bossyns, Albert J., 4122 Kathland Avenue—7
Bowe, Dudley P., 2 W. Read Street—1
Bowie, Harry Clay, 1011 N. Calvert Street—2
Bowie, Helen, 3927 Canterbury Road—18
Bowyer, Thomas S., Medical Arts Bldg.—1
Boyd, Charles Holmes, 24 E. Eager Street—2
Boyd, Kenneth B., 1114 St. Paul Street—2
Boyle, J. Brooks, Jr., 1226 St. Paul Street—2
Brack, Charles Bernard, 11 E. Chase Street—2
Brackin, John T., Jr., 346 Rosemary Avenue, Ambler, Pa.
Bradley, J. Edmund, University Hospital—1
Brady, Frank Joseph, 4530 Marble Hall Road—12
Brady, Leo, Medical Arts Bldg.—1

---

* Deceased.

Brager, Simon, 1800 N. Charles Street—1
Brandon, Russell R., 1606 Kelly Avenue—9
Branon, A. Brooks, Cambridge Arms Apartments—18
Brantigan, Otto C., 104 W. Madison Street—1
Breitstein, Moses L., 1213 Eutaw Place—17
Brendle, William K., Vanderbilt General Hospital, Nashville, Tenn.
Brennan, Thomas J., 5217 Harford Road—14
Brickman, Helen Cicely, Hospital for the Women of Maryland—17
Bridgman, E. W., 104 Elmhurst Road—10
Brinsfield, Carlton, 1231 Gleneagle Road—12
Bronushas, I. Benedict, 3037 O'Donnell Street—24
Bronushas, Joseph B. Bernard, 3037 O'Donnell Street—24
Brooks, Ross C., 2512 E. Monument Street—5
Brouillet, George H., 102 Dunkirk Road—12
Brown, Ernest Claiborne, Jr., 1101 N. Calvert Street—2
Brown, James, Jr., Medical Arts Bldg.—1
Brown, Paul, 3602 Liberty Heights Avenue—17
Brown, Webster H., 11 E. Biddle Street—2
Browne, James S., University Hospital—1
Browne, Rayner, 1500 E. Madison Street—5
Broyles, Edwin N., 1100 N. Charles Street—1
Brumback, Frank Edgar, 1339 Pentwood Road—12
Brumback, Joseph E., Medical Arts Bldg.—1
Brumback, Joseph E., Jr., 212 Goodale Road—12
Bubert, Howard M., Medical Arts Bldg.—1
Buchness, Anthony V., 110 E. Lombard Street—2
Buchness, John A., 110 E. Lombard Street—2
Buck, Walter B., 18 E. Eager Street —2
Bundick, William R., 840 Park Avenue—1
Burger, T. Terry, 3301 N. Charles Street—18
Burgin, Bernard, 6721 Reisterstown Road—15
Burnett, Jack M., 1401 Stonewood Road—12
Butler, W. W. S., III, 1940 McElderry St.—5
Butler, W. Berkley, 2033 Druid Hill Avenue—17
Byerly, M. Paul, 3033 W. North Avenue—16
Cahn, Charles A., 2145 W. Baltimore Street—23
Camp, Leah Rosenblatt, 3705 Liberty Heights Avenue—15
Camp, Oscar B., 3705 Liberty Heights Avenue—15
Campbell, Charles R., 718 Dolphin Street—17
* Cannon, Burdelle Sittler, 509 Medical Arts Bldg.—1
Cantrell, James R., Johns Hopkins Hospital—5
Caplan, Lester H., 4208 Colonial Road—8
Carey, T. Nelson, 1014 St. Paul Street—2
Carliner, Paul Elliott, 2217 South Road—9
* Carman, Richard Perry, 3602 Frederick Avenue—29
Carozza, Anthony F., 5217 York Road—12
Carr, Charles E., 6201 York Road —12
Carr, James D., 1427 Madison Avenue—17
Carroll, H. Roland, 4202 Charlcote Road—18
Casler, DeWitt B., 13 W. Chase Street—2
Castagna, Joseph V., 1011 N. Charles Street—2
Chalfant, A. Stuart, 6210 York Road—12
Chambers, Earl Leroy, 4108 Liberty Heights Avenue—7
Chambers, Ewan Buchanan, 3408 St. Paul Street—18
Chambers, John W., 18 W. Franklin Street—1
Chambers, Robert George, 945 Ellicott Driveway—16
Chambers, Thomas R., 18 W. Franklin Street—1
Chant, Harry L., Johns Hopkins Hospital—5
Chase, William Edward, Div. of Urology, Henry Ford Hospital, Detroit 2, Mich.
Chatard, Ferdinand Edme, IV, 15 E. Biddle Street—2
Chatard, J. Albert, 15 E. Biddle Street—2
Checket, Pierson M., 1801 Eutaw Place—17
Chenowith, Robert Franklin, 1114 St. Paul Street—2
Chesney, Alan M., 1419 Eutaw Place—17
Chiodi, Nathan E., 1116 St. Paul Street—2
Chisolm, J. J., 6 E. Eager Street—2
Clapp, Clyde A., 513 N. Charles Street—1
Classen, John Newell, 2923 St. Paul Street—18
Cleary, Louis F., 6420 Reisterstown Road—15
Clemens, Raymond L., 3 Upland Rd. —10
Clemson, Earl P., 701 Cathedral Street—1
Clough, Paul W., 24 E. Eager Street —2
Cobb, John Candler, 615 N. Wolfe Street—5
Coblentz, R. G., 11 E. Chase Street —2
Cohen, Bernard J., Marlborough Apts.—17
Cohen, Harry, 803 Cathedral Street —1
Cohen, Irvin H., U. S. Army Hospital, Fort Sill, Okla.
Cohen, Jonas Harold, 6702 Park Heights Avenue—15
Cohen, Morris M., 1115 St. Paul Street—2
Cohn, L. Clarence, 3301 N. Charles Street—18
Cole, Alfred, 136 S. Hilton Street —29
* Cole, John Wesley, 6604 Loch Raven Blvd.—Towson 4
Cole, Norman Brown, University Club—1
Coleman, William J., 2810 Chelsea Terrace—16

---

* Deceased.

Collenberg, H. T., 2 W. Read Street—1

Collins, James M., 3321 Frederick Avenue—29

Colston, J. A. C., 1201 N. Calvert Street—2

Compton, Beverley C., 1014 St. Paul Street—2

Conley, C. Lockard, 120 E. Lake Avenue—12

Conn, Jacob Harry, 2325 Eutaw Place—17

Connolly, Harry John, 13 E. Eager Street—2

Constadt, Hans Walter, 814 Medical Arts Bldg.—1

Cook, Elmer E., Jr., 2431 Maryland Avenue—18

Cook, Sarah, 2609 Lee Boulevard, Apt. 202, Arlington 4, Va.

Cooley, Robert N., Johns Hopkins Hospital—5

Cooper, Theodore, 2201 Eutaw Place—17

Cope, Clyde B., Personnel Health Clinic, Johns Hopkins Hospital—5

Copeland, Herbert B., 2237 Eutaw Place—17

Cordi, Joseph M., 1261 E. Belvedere Avenue—12

Cornbrooks, Ernest I., Jr., Medical Arts Bldg.—1

Costantini, John, 234 S. Conkling Street—24

Cotter, Edward Francis, 6 E. Read Street—2

* Cotton, Albertus, 101 E. Preston Street—2

Covington, E. Eugene, 828 Park Avenue—1

Cox, William Franklin, 3rd, 3006 Deepwood Road—18

Crimy, Charles P., 2722 E. Monument Street—5

Crocker, Melvin Hugh, 1204 St. Paul Street—2

Crosby, Robert MacGonicle Nelson, 11 E. Chase Street—2

Cross, Ernest S., 1030 N. Calvert Street—2

Cross, Ernest S., Jr., 4408 Atwick Road—10

Cross, Richard J., Randolph Field, Tex.

Crowe, Samuel J., Tuscany Apartments—10

Crowther, Aloho H., 4209 Frederick Avenue—29

* Cullen, Thomas Stephen, 20 E. Eager Street—2

Cumin, Milton H., 4302 Springdale Avenue—7

Cunningham, Raymond M., 11 E. Chase Street—2

Currie, Dwight McI., 11 E. Chase Street—2

Curtis, Raymond M., 113 Beechdale Road—10

Daly, Harold Lawrence, Jr., 3300 W. North Avenue—16

Daly, Miriam Shamer, 3300 W. North Avenue—16

Dana, Edward R., 4214 Greenway—18

Dandy, Walter E., Jr., 700 W. Melrose Avenue—10

Daniels, Thomas F., 6 E. Eager Street—2

D'Antonio, Joseph, 127 Riverthorn Road—20

Darby, William Arthur, Medical Arts Bldg.—1

Davidov, Nathan J., 3218 Eastern Avenue—24

Davidson, Charles Nuchols, Medical Arts Bldg.—1

Davidson, Nachman, 812 Park Avenue—1

Davies, Arthur J., 800 W. 33rd Street—11

Davis, E. Hollister, 3301 N. Charles Street—18

Davis, Frank Willard, Jr., Johns Hopkins Hospital—5

Davis, John R., Jr., Medical Arts Building—1

Davis, Marvin Hersch, 803 Cathedral Street—1

Davis, William Bowdoin, 701 Cathedral Street—1

Day, Newland Edward, 4 E. 33rd Street—18

Deane, Garrett E., 5402 Edmondson Avenue—29

Debuskey, Matthew, 2412 Eutaw Place—17

DeCarlo, John, Jr., 1211 Cochran Avenue—12

Deckert, William Allen, 1114 St. Paul Street—2

De Hoff, George W., 2020 N. Charles Street—18

De Hoff, John Burling, 2020 N. Charles Street—18

Deibel, Harry, 1224 Hanover Street—30

Delfs, Eleanor, Johns Hopkins Hospital—5

Demarco, Salvatore, Jr., 715 N. Charles Street—1

Dennis, John Murray, University Hospital—1

Denny, Walter L., Brady Urological Institute, Johns Hopkins Hospital—5

De Vincentis, Michael Louis, 11 E. Chase Street—2

Dickey, Francis G., 736 Northern Parkway—12

Dickson, Lawrie C., Jr., 1373 Cadieus Road, Grosse Point 30, Mich.

Diehl, William K., 11 E. Chase Street—2

Diener, Louis, 2449 Eutaw Place—17

Diggs, Everett S., 11 E. Chase Street—2

Di Paula, Anthony F., 11 E. Chase Street—2

Dix, Harold C., 405 N. Charles Street—1

Dixon, Alfred B., 229 E. 33rd Street—18

Dixon, Darius McClelland, Medical Arts Bldg.—1

Dixon, William Thomas, Ft. Sam Houston, Tex.

Dobihal, Louis Charles, 447 N. Kenwood Avenue—24

Dodd, William A., 700 N. Charles Street—1

Doeller, Charles Henry, Jr., 1025 N. Calvert Street—2

Doran, William T., Jr., 221 W. Lanvale Street—17

Dorf, Herman J., 3103 Garrison Blvd.—16

Dorman, John William, Jr., 1305 Round Hill Road—18

Douglass, Carleton Cecil, 15 E. Biddle Street—2

Douglass, Louis H., University Hospital—1

Doukas, James A., 3810 Lochern Drive—7

Drenga, Joseph F., 209 S. Chester Street—31

Drozd, Joseph, 240 S. Ann Street—31

---

* Deceased.

Dudley, Albert Henry, Jr., 1559 Sheffield Road—18
Duffy, William C., 1120 St. Paul Street—2
Dugan, Hammond J., Jr., 15 E. Biddle Street—2
Dumler, John C., Medical Arts Building—1
Dunnigan, William C., 4916 Harford Road—14
Dwyer, Frank P., Jr., 2507 Lyon Street, Hillcrest Hgts., Wash. 20, D. C.
Eareckson, Vincent O., Jr., 2309 Elsinor Avenue—16
Eastland, John Sheldon, Medical Arts Bldg.—1
Eastman, Nicholson J., Johns Hopkins Hospital—5
Eaton, George O., 4 E. Madison Street—2
Eaton, W. Drummond, 11 E. Chase Street—2
Ebeling, Karl W., 3311 St. Paul Street—18
Ebeling, William Carl, University Hospital—1
Edel, John W., Jr., 3403 Garrison Avenue—15
Edgerton, Milton T., Johns Hopkins Hospital—5
Edlow, Ernest S., 2353 Eutaw Place—17
Edmunds, Page, 4417 Underwood Road—18
Edwards, C. Reid, University Hospital—1
Edwards, Monte, Medical Arts Bldg.—1
Ehrlich, Daniel, 3911 Wabash Avenue—15
Eisenberg, Albert, 2200 Mayfield Avenue—13
Eisenberg, Leon, 1801 W. Baltimore Street—23
Elder, John D., Jr., Barnes Hospital, 600 S. Kingshighway, St. Louis 10, Mo.
Eleder, Franklin Charles, 2201 Echodale Avenue—14
Elgin, William Worcester, Sheppard and Enoch Pratt Hospital, Towson—4
Ellis, Francis A., 8 E. Madison Street—2
Ellison, Emanuel S., 107 E. West Street—30
English, Max R., 5713 Belair Road—6
Ensberg, Dorence L., V. A. Hospital, 3900 Loch Raven Blvd.—18
Ephraim, Meyer, 443 E. 25th Street—18
Erwin, John J., Medical Arts Bldg.—1
Evans, John, Medical Arts Bldg.—1
Everett, Houston Spencer, 11 E. Chase Street—2
Ewald, August L., 36 York Court—18
Faraino, Frank A., Baltimore City Hospitals—24
Farber, George J., 1037 St. Paul Street—2
Fargo, Lee K., 1800 N. Charles Street—1
Farley, Julie, 418 Northway—18
Fearing, William Lumsden, 3025 Belair Road—13
Feinglos, Israel J., 2002 E. Pratt Street—31
Feldman, Maurice, 747 Lake Drive—17
Feldman, Maurice, Jr., Latrobe Apts.—2
Feldman, S. Charles, 1440 E. Baltimore Street—31
Fenby, John S., 3522 Greenmount Avenue—18
Ferguson, W. Richard, 1107 St. Paul Street—2
Field, Arnold Lewis, 901 Cathedral Street—1
Filtzer, David Leonard, 1411 Eutaw Place—17
* Fine, Morris A., 118 Aisquith Street—2
Fineman, Jerome, 3700 Garrison Blvd.—15
Finesinger, Jacob Ellis, Dept. of Psychiatry, Univ. of Md. School of Medicine—1
Finkelstein, Abraham H., 11 E. Chase Street—2
Finkelstein, Ruth, Medical Arts Building—1
Finney, George Gross, 2947 St. Paul Street—18
Finney, John M. T., Jr., 2947 St. Paul Street—18
Firor, Warfield M., 1101 N. Calvert Street—2
Firor, Whitmer B., 1100 N. Charles Street—1
Fishel, Elliott Raphael, 821 Chauncey Avenue—17
Fisher, A. Murray, 18 E. Eager Street—2
Fisher, Russell S., 934 Dulaney Valley Road—Towson 4
Fisher, William A., Jr., 20 Blythewood Road—10
Fitzpatrick, Vincent de Paul, Jr., 1120 St. Paul Street—2
* Fleck, Harvey K., 2940 Wyman Parkway—11
Fleischer, Walter E., 3400 E. Chase Street—13
Flippin, Eugene L., 2612 Elsinore Avenue—16
Flynn, Philip Daniel, 11 E. Chase Street—2
Ford, James Arthur, 4638 Homestead Road, Jacksonville, Fla.
Fordyce, Cless Y., 1001 St. Paul Street—2
* Forsythe, Hugh, 424 E. North Avenue—2
Fort, Wetherbee, 1118 St. Paul Street—2
Foster, Herbert M., 2824 St. Paul Street—18
Fox, Lay Martin, 5001 Midwood Avenue—12
Fox, Samuel Louis, 1205 St. Paul Street—2
Frank, Jerome D., 603 W. University Parkway—10
* Franklin, David, 122 W. Lee Street—1
Franklin, Haswell D., 1123 St. Paul Street—2
Franz, J. Howard, 1127 St. Paul Street—2
Frederickson, Howard N., 3813 Patterson Ave.—7
Freedom, Leon, 1031 St. Paul Street—2
Freeman, Norman Randolph, Jr., 210 Northway—18
Frenkil, James, 1422 Park Avenue—17
Frey, Edward L., Jr., 2 W. Read Street—1
Frey, E. William, 1928 Pennsylvania Avenue—17
Fried, Hiram, Medical Arts Bldg.—1
Friedenwald, Edgar B., 1616 Linden Avenue—17
Friedenwald, Jonas S., 1212 Eutaw Place—17
Friedman, Hyman P., 1319 Light Street—30

---

* Deceased.

Friedman, Joseph, 404 E. North Avenue—2
Friedman, Marion, 1737 E. North Avenue—13
Friedman, Paul N., 3804 Fairview Avenue—16
Fuller, Harvey L., 5718 Ridgedale Road—9
Furnari, Joseph C., University Hospital—1
Furstenberg, Frank F., 812 Park Avenue—1
Fusting, William H., 11 E. Chase Street—2
Futcher, Palmer H., Department of Medicine, Johns Hopkins Hospital—5
Futterman, Perry, Latrobe Apartments—2
Gaber, Jerome, 3915 Fordleigh Road—15
Gaither, Ernest H., 12 E. Eager Street—2
Gallant, Leonard J., The Latrobe Apartments—2
Galvin, Gerald A., 322 Suffolk Road—18
Galvin, Thos. K., 113 W. Monument Street—1
Ganey, Joseph B., Professional Building, Bradenton, Fla.
Gann, Mark E., 2800 Lawina Road—16
Gardner, Francis Sidney, Jr., 1684 Waverly Way—12
Gareis, Louis C., 1651 Northwick Court—18
Garis, Robert William, 1103 St. Paul Street—2
Garlick, William L., 700 N. Charles Street—1
Garrett, Richard M., Medical Arts Building—1
Garrison, Alfred S., 2 E. Read Street—2
Gaskel, Jason H., 637 S. Conkling Street—24
Gaver, Leo J., 1 Mallow Hill Avenue—29
Gay, Leslie Newton, 1114 St. Paul Street—2
Gehlert, Sidney R., Jr., 4700 Pennington Avenue—23
Gellman, Moses, 1411 Eutaw Place—17
Genecin, Abraham, 1406 Eutaw Place—17
Gentry, William D., Jr., Heatherfield Road—10
Geraghty, Francis Jos., 3047 St. Paul Street—18
Geraghty, Wm. R., 2225 St. Paul Street—18
Gerlach, James Johnson, 4 E. Eager Street—2
Gibbons, J. Robert, 3 Elmhurst Road—10
Gibbs, Gordon E., University Hospital—1
Giering, Herman J., 3906 Parkside Drive—6
Gilbert, Charles Richard Alsop, Box 285, Juncos, Puerto Rico
Gilkes, Evan A., 601 N. Calhoun Street—17
Gillis, Andrew Colin, 1033 N. Calvert Street—2
Gillis, Francis W., 1800 N. Charles Street—1
Gilmore, William E., 108 E. 33rd Street—18
Gimbel, Harry S., 2703 Edmondson Avenue—23
Ginsberg, Milton, 3504 Erdman Avenue—13
Ginsburg, Leon, 529 N. Charles Street—1
Glass, Frederic Arthur, 845 Park Avenue—1
Glassman, Lionel, 6002 Wallis Avenue—15
Glick, Samuel S., 3914 Park Heights Avenue—15
Gluck, Francis Wilcox, 100 W. University Parkway—10
Gluck, Julius C., 5356 Reisterstown Road—10
Godlove, John Carlton, 409 West King Street, Martinsburg, W. Va.
Goldbach, Leo John, 6 E. Eager Street—2
Goldberg, Herman K., 807 Cathedral Street—1
Goldberg, Raymond B., 803 Cathedral Street—1
Goldberg, Sigmund, 1422 Park Avenue—17
Goldberg, Sylvan D., 4412 Elderon Avenue—15
Goldberg, Victor, 1701 Eutaw Place—17
Goldman, Abram, 5501 Powhatan Avenue—16
Goldman, Harris, 1816 W. North Avenue—16
Goldman, Harry, 2326 Eutaw Place—17
Goldsborough, Charles R., 2923 St. Paul Street—18
Goldstein, A. E., 3505 N. Charles Street—18
Goldstein, Eugene O., 3911 Brookhill Road—15
Goldstein, Marvin, 5334 Liberty Heights Avenue—7
Goldstone, Herbert, 1810 Eutaw Place—17
Golley, Kyle W., 5103 Harford Road—14
Golombek, Leonard H., 227 Audrey Lane—Apt. 102, Washington 20, D. C.
Goodman, Howard, 1513 N. Milton Avenue—13
Goodman, Jerome Edward, 809 Cathedral Street—1
Goodman, Julius H., 3400 E. Baltimore Street—24
Goodman, Louis E., 1211 Eutaw Place—17
Goodman, Sylvan Chauncey, 2202 Park Avenue—17
Gordon, Harry H., Sinai Hospital—5
Gordy, Lyle L., 5106 Harford Road—14
Gorten, Martin K., 4 E. 32nd Street—18
Gould, John Joseph, 14 N. East Avenue—24
Govatos, George, Med. Arts Bldg.—1
Govons, Sidney Robert, 3923 W. Rogers Avenue—15
Grafflin, Allan L., 215 Edgevale Road—10
Graham, R. Walter, 1014 St. Paul Street—2
Granoff, Hymen L., 2240 Eutaw Place—17
Gray, Watson W., 1014 St. Paul Street—2
Graziano, Theodore J., 4019 Alameda Blvd.—18
Green, John Summerfield, III, 109 E. Melrose Avenue—12
Greenberg, Sahler M., 4613 Eastern Avenue—24
Grempler, Walter E., 1013 Poplar Grove Street—16
Grenzer, William H., 1520 E. 33rd Street—18
Grimes, S. Butler, 100 W. University Pkwy.—10
Grob, David, 3406 Cederdale Road—15
Grose, William Edwin, 1201 N. Calvert Street—2

Gross, Joseph Bernard, 2404 Eutaw Place—17
Grossman, I. Karl, 1212 N. Patterson Park Avenue—13
Grott, Harold Allan, 8100 Harford Road—14
Grubb, Wilson, 4 E. 33rd Street—18
Grumbine, Francis L., 411 Chapelgate Lane—29
Gubnitsky, Albert, 5415 Park Heights Avenue—15
Gundersheimer, Herbert N., Cordova Apartments, Lake Drive—17
Gundry, Lewis P., Relay 27, Md.
Gundry, Rachel K., Athol, Catonsville—29
Gutman, Isaac, 817 St. Paul Street—2
Guttmacher, Manfred S., 1109 N. Calvert Street—2
Guyton, Jack Smallwood, Johns Hopkins Hospital—5
Guyton, J. Willis, 1207 E. 36th Street—18
Haase, John Henry, 4218 Harford Road—14
Hachtel, Frank W., 122 W. Lafayette Avenue—17
Hahn, Richard D., 1823 Park Avenue—17
Haines, John S., 11 E. Chase Street—2
Halebian, Hratch S., 6003 Bryan Parkway, Dallas, Tex.
Hall, Arthur T., Jr., 2 E. Read Street—2
Hall, Elmer G., 1631 E. North Avenue—13
Hall, William S., 215 Woodlawn Road—10
Hamburger, Louis P., 1207 Eutaw Place—17
Hamburger, Louis P., Jr., 1207 Eutaw Place—17
Hammer, Howell I., 1929 Edmondson Avenue—23
Hanchett, Richard B., Medical Arts Building—1
Handelsman, Jacob Charles, 1112 N. Calvert Street—2
Hankin, Samuel J., 2331 Eutaw Place—17
* Hanrahan, Edward M., Jr., 1201 N. Calvert Street—2
Hanson, Arthur M., 40 Maple Drive—28
Harbold, Harold V., 4706 Harford Road—14
Hardy, Janet B., Glenarm, Md.
Harmon, Louis E., 2224 Madison Avenue—17
Harper, Paul, 615 N. Wolfe Street—5
Harris, S. Elliott, 3701 Calloway Avenue—15
Harris, Thomas W., 1824 W. Franklin Street—23
Harrison, Edmund P. H., 2903 N. Charles Street—18
Harrison, Harold E., 3001 Fordney Lane—7
Hart, Jeremiah A., 311 W. 31st Street—11
Hartman, Oscar, 1801 Eutaw Place—17
Hartman, William L., 5831 The Alameda—18
Hartz, Alvin S., 4017 Elderon Avenue—15
Hartz, Jerome, 11 E. Chase Street—2
Harvey, A. McGehee, Johns Hopkins Hospital—5
Harvey, John Collins, 500 N. Washington Street—5
Hawkins, John Frederick, Jr., Dividing Road, Manhattan Beach, Severna Park, Md.
Haws, John March, 1101 N. Calvert Street—2
Hayleck, Mary L., 4401 Underwood Road—18
Hayward, Eugene H., 115 E. Eager Street—2
Healy, Robert F., Medical Arts Bldg.—1
Hebb, Donald B., Cockeysville, Md.
Heghinian, Jeanette R., 2212 South Road—9
Heldrich, Frederick Joseph, Jr., 1156 Longwood Street—16
Helfrich, Raymond F., 519 Lyndhurst Street—29
Helfrich, William G., 5006 Roland Avenue—10
Henning, Emil Heller, Jr., 601 Winans Way—29
Hensen, Henry Mathias, 0261356, 279th Station Hospital, APO 742, ℅ Postmaster, New York, N. Y.
Herman, N. B., 1041 St. Paul Street—2
Herold, Paul Garmer, 1222 Walters Avenue—12
Hersperger, W. Grafton, 12 E. 33rd Street—18
Hewitt, J. Frank, 922 W. University Pkwy.—10
* Hibbits, John Thomas, Medical Arts Bldg.—1
Higgins, I. Bradshaw, 2243 Madison Avenue—17
Highstein, Benjamin, 121 S. Highland Avenue—24
Highstein, Gustav, 3503 Garrison Blvd.—15
Hill, Lewis B., Sheppard-Enoch Pratt Hospital, Towson 4, Md.
Hills, Ralph G., 18 E. Eager Street—2
Himelfarb, Albert Joseph, 1801 Eutaw Place—17
Hirshfeld, John H., 6919 Harford Road—14
Hobelman, Charles F., 3915 Juniper Road—18
Hoffman, Elmer, 3200 Carlisle Avenue—16
Hoffman, Reuben, 3602 Forest Park Avenue—16
Hogan, J. F., 7 E. Preston Street—2
Holden, Frederick A., Medical Arts Building—1
Hollander, David H., 5514 Kemper Road—10
Holljes, Henry Wirt Duvall, 3308 W. North Avenue—16
* Holly, Julius David, 7701 Seven Mile Lane—8
Holt, Earl K., 407 Sudbrook Road—8 Pikesville
* Homer, Harry L., Riderwood, Md.
Hood, Bowman J., 317 Broxton Road—12
Hooper, Z. Vance, 3534 Ellerslie Avenue—18
Hopkins, H. Hanford, 1201 N. Calvert Street—2
Hopkins, James E. T., 104 W. Madison Street—1
Hopkins, John Vernon, 129 E. Redwood Street—2
Horine, Cyrus F., Medical Arts Bldg.—1
Horning, Edward Douglas, 18 W. Franklin Street—1
Horton, William Preisz, 3411 Guilford Terrace—18
Howard, John Eager, Johns Hopkins Hospital—5

---

* Deceased.

Howard, John Tilden, 12 E. Eager Street—2

Huffer, Virginia, Spring Grove Hospital—28

Hull, Harry Clay, Medical Arts Bldg.—1

Hulla, Jaroslav, 2214 E. Fayette Street—31

Hundley, J. Mason, Jr., Medical Arts Bldg.—1

Hunner, Guy Le Roy, Medical Arts Bldg.—1

Hurwitz, Abraham B., 3048 W. North Avenue—16

Hurwitz, Chester E., 2218 Eutaw Place—17

Hutchins, Amos F., 1227 N. Calvert Street—2

Hutchins, Elliott H., 1227 N. Calvert Street—2

Hyde, Harry C., 1100 E. North Avenue—2

Hyle, John Charles, 106 N. Potomac Street—24

Hyman, Calvin, 2356 Eutaw Place —17

Hyman, Nathan B., 2502 W. Rogers Avenue—15

Iliff, Charles Edwin, 12 W. Read Street—1

Ingalls, George Sam, 703 Cathedral Street—1

Insley, J. Knox, Jr., 4312 Parkside Drive—6

Isaacs, Benjamin H., 2600 E. Baltimore Street—24

Jackson, Robert L., 600 N Arlington Avenue—17

Jacobs, Louis L., 1700 Eutaw Place —17

Jacobson, Meyer William, 2310 Eutaw Place—17

Jaffe, Marvin, 1101 N. Calvert Street —2

Jahreiss, Walter O., 4212 Patterson Avenue—15

Jandorf, R. Donald, Riviera Apts., 3-J, Lake Drive—17

* Janney, Francis W., 405 N. Charles Street—1

Janney, Nathan 7101 Harford Road —14

Januszeski, Francis J., 540 N. Lin wood Avenue—5

Jarrett, Edwin B., 11 E. Chase Street —2

Jaworski, Melvin J., 2711 Eastern Avenue—24

Jennings, F. Leslie, Medical Arts Bldg.—1

Jeppi, Joseph, 10 E. Read Street—2

Jerardi, Joseph V., 107 Armagh Drive—12

Jewett, Hugh J., 1201 N. Calvert Street—2

Johns, Thomas Nelson Page, Johns Hopkins Hospital—5

Johnson, Edward S., 203 Chancery Road—18

Johnson, Elliott W., 3432 Frederick Road—29

Johnson, Marius P., Medical Arts Bldg.—1

Johnson, Robert W., Jr., 4 E. Madison Street—2

Johnson, Robert W., III, 1014 St. Paul Street—2

Johnson, William R., Medical Arts Bldg.—1

Jones, Benjamin F., 5F Garden Apartments—10

Jones, Everett D., 101 E. Biddle Street—2

Jones, Georgeanna Seegar, Medical Arts Building—1

Jones, H. Alvan, 1107 St. Paul Street —2

Jones, Howard W., Jr., Medical Arts Building—1

Josephs, David, U. S. Army Hospital Ft. Campbell, Kentucky

Joska, Vincent V., 3714 Loch Raven Blvd.—18

Joslin, Blackburn Smith, 105 Woodlawn Road—10

Joslin, C. Loring, 11 E. Chase Street—2

Kadan, Ferd E., 1308 Ramblewood Road—12

Kader, Benjamin, 2306 Eutaw Place —17

Kallins, Edward S., 4300 Liberty Heights Avenue—7

Kaltreider, D. Frank, 1526 Northwick Road—18

Kammer, William H., Jr., 612 W. 40th Street—11

Kane, Harry F., 913 E. Belvedere Avenue—12

Kaplan, Isadore, 3314 Marnat Road —8

Kappelman, Melvin D., 817 St. Paul Street—2

Kardash, Theodore, Medical Arts Building—1

Karfgin, Arthur, Northwood Apts.—18

Karfgin, Walter E., 4331 Harford Road—14

Karns, Clyde F., Medical Arts Bldg. —1

Karns, James R., 700 Cathedral Street—1

Kates, Harry Franklin, 517 Scott Street—30

Katzenberger, James W., Medical Arts Bldg.—1

Kayser, Fayne Albert, Medical Arts Bldg.—1

Keller, Charles J., 222 W. Monument Street—1

Kelly, Bernard V., National Marine Bank Bldg.—2

Kelly, Vernon C., 13 E. Eager Street —2

Kelmenson, Harry, 1308 Eutaw Place —17

Kemick, Irvin B., 5416 Reisterstown Road—15

Kemler, J. I., 1908 Eutaw Place—17

Kemp, Katherine Virdin, 1300 Wildwood Parkway—29

Keown, Lauriston L., 431 E. Lake Avenue—12

* Keown, Thomas William, 1938 Linden Avenue—17

Kerman, Edward F., 3700 Liberty Heights Avenue—15

Kern, Howard M., Esplanade Apartments—17

Ketron, Lloyd W., 1125 St. Paul Street—2

Keyser, R. L., Wentworth Apts.—1

Kieffer, Richard F., 200 W. Baltimore Street—1

Kieffer, Richard F., Jr., 5220 Springlake Way—12

Kiel, August, Jr., 1715 Northbourne Road—14

Kilby, Walter L., Medical Arts Bldg. —1

Kimberly, Robert C., 802 Cathedral Street—1

Kimzey, F. J., 2700 Harford Avenue —18

King, John Theodore, 1210 Eutaw Place—17

King, Joseph D. B., 404 Hawthorn Road—10

---

* Deceased.

Kirby, Francis Joseph, 110 E. North Avenue—2
Kirkpatrick, Crawford N., Jr., 6 E. Eager Street—2
Kirsh, Milton B., 2320 Eutaw Place—17
Kitlowski, Edward A., 3301 N. Charles Street—18
Kleiman, Bernard S., 1113 N. Calvert Street—2
Kleiman, Norman R., 3803 Edmondson Avenue—29
Klemkowski, Irvin P., 11 E. Chase Street—2
Klijanowicz, Stanley B., 3500 Erdman Avenue—13
Klimes, Louis F., 2623 E. Monument Street—5
Klinefelter, Harry F., Jr., 1101 N. Calvert Street—2
Kloman, E. H., 44 W. Biddle Street—1
Klotz, Ben, 817 St. Paul Street—2
*Knapp, Hubert Clement, 3123 N. Calvert Street—18
Knipp, George A., 4116 Edmondson Avenue—29
Knipp, Harry Lester, 4116 Edmondson Avenue—29
Knowles, F. Edwin, Jr., 513 N. Charles Street—1
*Knox, J. H. M., Jr., 2919 St. Paul Street—18
Knox, James H. Mason, III, 600 W. Belvedere Ave.—10
Kochman, Leon A., 3508 Dennison Road—15
Kohlerman, Nicholas John, The Latrobe—2
Kohn, Walter, 102 E. Fort Avenue—30
Kolman, Lester N., 3700 Park Heights Avenue—15
Kolodner, Louis J., 2502 Eutaw Place—17
Konigsberg, Wilfred K., 1211 Eutaw Place—17
Koontz, Amos R., 1014 St. Paul Street—2
Kourey, Salem W., 4404 Bedford Place—18
Krause, Louis, 11 E. Chase Street—2
Kremen, Abraham, 2355 Eutaw Place—17
Krepp, Martin W., 4202 Kolb Avenue—6
Kress, Milton B., Medical Arts Building—1
Krieg, Edward L. J., 5019 Old Frederick Road—29
*Kroll, Louis J., 4101 Springdale Avenue—7
Krulevitz, Keaciel K., 244 N. Hilton Street—29
Krumrein, Louis Frederick, 722 N. Kenwood Avenue—5
Kunkowski, Andrew, 2529 Eastern Avenue—24
Kurland, Albert A., 817 St. Paul Street—2
Kyper, Fred T., 421 Medical Arts Building—1
Lachman, Harry, 2322 Callow Avenue—17
Laforest, Albert L., 822 N. Bond Street—5
Lally, Leo A., 3517 Edmondson Avenue—29
Lambros, Byruth Lenson, 213 Mallow Hill Rd.—29
Lang, Milton Charles, 2117 Belair Road—13
Langeluttig, Harry Vernon, 715 N. Charles Street—1
Langworthy, Orthello R., 1503 Bolton Street—17
Laroque, Herbert E., 1800 N. Charles Street—1
Lasell, Eldridge L., Greenway Apartments, 34th and Charles Streets—18
Latham, Ernest Floyd, Johns Hopkins Hospital—5
Latham, Doris Vivian, Johns Hopkins Hospital—5
Laukaitis, Joseph, 679 Washington Blvd.—30
Lavenstein, Arnold F., 5715 Oakshire Road—9
Lavy, Louis T., 1844 W. North Avenue—17
Leach, C. Edward, 14 E. Eager Street—2
Lebo, Lester, Medical Arts Bldg.—1
Lederman, Edward I., 4504 Maine Avenue—7
LeDoux, Clarence W., 3023 Eastern Avenue—24
Leftwich, Charles I., 807 Radnor Avenue—12
Legge, John E., 700 Cathedral Street—1
Legge, Kenneth Dartmouth, Medical Arts Bldg.—1
Legum, Samuel, 1261 E. North Avenue—2
Leitz, Thomas Frederick, Temple Garden Apts.—17
Lenhard, Raymond E., 1107 St. Paul Street—2
Lerner, Philip F., 1111 St. Paul Street—2
Leslie, Franklin Earl, 623 Wilton Road—Towson 4
Levi, J. Elliott, 1020 St. Paul Street—2
Levickas, Herbert J., 5305 E. Drive—27
Levin, H. Edmund, 3400 Hilton Road—15
Levin, Manuel, 4818 Reisterstown Road—15
Levin, Milton, 2224 Eutaw Place—17
Levin, Morris Benjamin, 218 E. University Parkway—18
Levine, Stuart Charles, 809 Cathedral Street—1
Levy, Charles S., Medical Arts Bldg.—1
Levy, Isadore I., 3530 Hilton Street—15
Levy, Kurt, 3103 N. Charles Street—18
Lewis, J. L., Jr., 5907 Wakehurst Way—12
Lewison, Edward F., 1020 St. Paul Street—2
Liberles, Lucille, 1739 Eutaw Place—17
Liberto, Joseph R., 1011 N. Charles Street—1
Lieberman, Alfred T., 29 E. Mt. Vernon Place—2
Lilianthal, Joseph L., Jr., Johns Hopkins Hospital—5
Lilienfeld, Samuel, 714 E. Preston Street—2
Lillich, B. A., 3615 Falls Road—11
Linas, Sydney, 2240 Eutaw Place—17
Linden, Harry, 14 S. Broadway—31
Li Pira, Joseph Francis, Box 1145 McClellan, AFB, McClellan, Cal.
Lippy, George Dewey, 206 Kimble Road—18
Lisansky, E. Theodore, 3210 Liberty Heights Avenue—15
Little, Luther E., 10 W. Madison Street—1

---

* Deceased.

Livingston, Samuel, 1039 St. Paul Street—2
Lloyd, Oliver S., 701 Cathedral Street—1
Loch, Walter Edward Eric, 1039 N. Calvert Street—2
* Locher, R. W., 31 E. North Avenue—2
Lockard, James Douglas, 802 Cathedral Street—1
Loewald, Hans W., 11 E. Chase Street—2
Loker, F. Ford, 1120 St. Paul Street—2
Long, John Herman, 11 E. Chase Street—2
Long, Wilmer Newton, Jr., 11 E. Chase Street—2
Longcope, Warfield T., Cornhill Farms, Lee, Mass.
* Looper, Edward A., 104 W. Madison Street—1
Love, William S., Jr., 1214 N. Calvert Street—2
Lovitt, William V., Jr., 3501 St. Paul Street, Apt. 423—18
Lowenbach, Hans, Duke University Hospital, Box 3518, Durham, N. C.
Lowitz, Irving Robert, 3815 Oakford Avenue—15
Lowman, Milton E., 4843 Park Heights Avenue—15
Lubin, Paul, 320 Patapsco Avenue—25
Luetscher, John Arthur, 12 E. Eager Street—2
Lumpkin, Morgan LeRoy, 914 N. Charles Street—1
Lumpkin, William R., 307 E. 33rd Street—18
Lupo, Deonis M., 11 E. Chase Street—2
Lynn, William Dawson, 1547 Northgate Road—18
McAllister, William B., New Haven Hospital, New Haven, Conn.
McCarthy, Charlotte, 618 Medical Arts Bldg.—1
McCarty, Harry D., 37 W Preston Street—1
McCauley, A. Franklin, 2843 St. Paul Street—18
McClafferty, William J., 315 St. Dunstans Road—12
McClary, Allen R., 411 Alabama Road—Towson, 4
* McConachie, Alexander Douglas, 805 N. Charles Street—1
McCormack, Lloyd L., 111 E. Preston Street—2
McCosh, James N., 312 Dixie Drive—4
McDonald, George, 844 N. Carey Street—17
McDonnell, Edmond J., 4 E. Madison Street—2
McElwain, Howard B., 31 E. North Avenue—2
McFadden, Robert B., 19 Wyndcrest Avenue—28
McGrady, Charles Winfred, Jr., University Hospital—1
McGrady, Kathleen Reilly, University Hospital—1
McGrath, Denis Joseph, 1 E. Randall Street—30
McKenzie, W. Raymond, Medical Arts Bldg.—1
McKusick, Victor A., Johns Hopkins Hospital—5
McLanahan, Samuel, 108 E. 33rd Street—18
MacLaughlin, D. C., 4508 Edmondson Village—29
McLaughlin, Francis Joseph, 2 E. Read Street—2
McLaughlin, John H., 3700 Loch Raven Blvd.—18
MacLean, Angus Lloyd, 1201 N Calvert Street—2
McLean, George, Medical Arts Bldg.—1
McLean, Ross L., 3900 Loch Raven Blvd.—18
MacMinn, Charles C., Jr., 2911 E. Baltimore Street—24
McNally, Hugh B., 1008 Winding Way—10
Mace, Albert J., The Terraces, Mt. Washington—9
Machen, John W., 6331 Belair Road—6
Macht, Allan Harris, 3818½ Belle Avenue—15
Macht, David I., 3420 Auchentoroly Terrace—17
Mackenzie, Thayer M., Johns Hopkins Hosp.—5
Mackowiak, Stephen C., 6714 Holabird Avenue—22
Macks, I. M., 3506 Liberty Heights Avenue—15
Maginnis, Helen Irene, 719 Medical Arts Bldg.—1
Magladerry, John William, Johns Hopkins Hospital—5
Mandy, Arthur Jennings, Medical Arts Bldg.—1
Mandy, Theodore E., Medical Arts Bldg.—1
Manieri, Frank V., 3503 Crossland Avenue—13
Mansdorfer, G. B., 2937 N. Charles Street—18
Mansfield, William K., 44 W. Biddle Street—1
Marburg, Rudolf, 2 E. Read Street—2
Marek, Charles B., 801 N. Luzerne Avenue—5
Marino, Frank C., 1129 St. Paul Street—2
Mark, Donald D., 3234 Lake Avenue—13
Markley, Raymond Law, Hospital for the Women of Md.—17
Markowitz, Milton, 8 E. Eager Street—2
Marr, Ernest G., 516 Cathedral Street—1
Marr, William G., 10 E. Chase St.—2
Marriott, Henry J. L., 5113 Brookgreen Road—29
Marshall, Curtis, Johns Hopkins Hospital—5
Marston, James G., 516 Cathedral Street—1
Martin, Lay, 1201 N. Calvert Street—2
Marvel, N. Clyde, Maryland Casualty Co.—3
Maser, Louis Robert, 4335 Park Heights Avenue—15
Maseritz, I. H., Temple Garden Apartments, Cloverdale Road and Madison Avenue—17
Mason, Robert E., 9 E. Chase Street—2
Massenburg, George Yellott, Apt. 270, 701 Hanlin Court, Ware Avenue, Wherry Housing Project, Scott Air Force Base, Ill.
Matchar, Joseph Charles, 3623 Liberty Heights Avenue—15
Maxson, Charles Walter, 817 St. Paul Street—2
May, Robert E., 1200 Woodbourne Avenue—12

---

* Deceased.

May, William T., 2034 Eutaw Place—17
Mayer, Erwin E., The Esplanade—17
Mays, Howard Brooks, 715 N. Charles Street—1
Mech, Karl F., 11 E. Chase Street—2
Menning, Joseph H., 101 W. Read Street—1
Meranski, Israel P., 3354 Dolfield Avenue—15
Merkel, Walter C., Union Memorial Hospital—18
Meyer, Eugene, III, 809 W. Lake Avenue—10
Michel, William, 1015 Poplar Grove Street—16
Michelson, Elliott, 1801 Eutaw Place—17
* Michelson, R. A., 2230 Eutaw Place—17
Milan, Albert Richard, 320 E. 33rd Street—18
Milan, Edward F., 682 Washington Blvd.—30
Millea, William Lawrence, 3101 St. Paul Street—18
Miller, Benjamin, 2030 Wilkins Avenue—23
Miller, Harry A., 2452 Eutaw Place—17
Miller, Isaac, 1228 S. Charles Street—30
Miller, Jacob M., 1613 E Baltimore Street—3
Miller, James Patton, 804 Cathedral Street—1
Miller, John Ernest, 719 Morningside Drive—Towson 4
Miller, Joseph G., 107 W. Saratoga Street—1
Miller, Lowell Stephen, Johns Hopkins Hospital—5
Miller, Meyer, 4832 Park Heights Avenue—15
Miller, Mitchell H., 311 Broxton Road—12
Miller, Stanley, 914 N. Charles Street—1
Milnor, William R., Malvern Avenue, Ruxton 4, Md.
Mintzer, Donald W., 1922 E. Belvedere Avenue—14
Mirick, George S., Johns Hopkins Hospital—5
Mitchell, George W., 11 E. Chase Street—2
Mitchell, Robert Bruce, Jr., 704 Cathedral Street—1
Mitchener, James Samuel, Jr., Church Home and Hospital—31
Mohr, Dwight H., 301 S. Ellwood Avenue.—24
*Moncure, Turner A., 100 St. Paul Street—2
Monninger, Arthur C., 800 E. North Avenue—2.
Moore, Alfred C., 2122 Broening Highway—24
Moore, James I., 11 E. Chase Street—2
Moore, Joseph Earle, Medical Arts Bldg.—1
Moore, Kirk, The Latrobe—2
Moore, Marcus W., Sr., 1371 N. Carey Street—17
Moores, J. Duer, 3105 Belair Road—13
Morgan, Russell H., Johns Hopkins Hospital—5
Morgan, Zachariah R., 10 E. Eager Street—2
Morris, Frank Kailer, 3913 Juniper Road—18
Morris, John David, 14 E. Eager Street—2
Morrison, John Huff, 6 E. Read Street—2
Morrison, Samuel, 11 E. Chase Street—2
Morrison, T. H., 11 E. Chase Street—2
Morrow, Andrew G., Leeds General Infirmary, Leeds, England
Mortimer, Egbert Laird, Jr., 207 Paddington Road—12
Mosberg, William Henry, Jr., 518 E. 39th Street—18
Moses, Benjamin B., 448 N. Luzerne Avenue—24
Moses, Bessie L., 519 Medical Arts Bldg.—1
Mostwill, Ralph, 1805 Eutaw Place—17
Muller, S. Edwin, 2 W. Read Street—1
Mulligan, E. James, 5600 Harford Road—14
Muncie, Wendell S., 11 E. Chase Street—2
Murgatroyd, George W., Jr., 1114 St. Paul Street—2
Murray, John Gardner, Jr., 3408 St. Paul Street—18
Muse, Joseph E., Jr., 5 West 29th Street—18
Muse, William T., 5 W. 29th Street—18
Myerowitz, Joseph Robert, 5145 Park Heights Avenue—15
Myers, John A., 104 E. Biddle Street—2
Myers, Joseph Carl, 1401 E. Cold Spring Lane—18
Myers, Myron Joseph, The Latrobe Apartments—2
Myers, Philip, 2425 Eutaw Place—17
Nachlas, I. William, 1109 N. Calvert Street—2
Nachlas, N. Edward, Rochester Court Apartments, Brooks Lane—17
Nance, Fuller, 522 Rossiter Avenue—12
Naquin, Howard A., Johns Hopkins Hospital—5
Needle, Nathan E., 2314 W. North Avenue—16
Neill, William, Jr., 901 Cathedral Street—1
Nelson, Alfred Turner, 4526 Marble Hall Road—12
Nelson, James Wharton, Earl Court Apts., Preston & St. Paul Streets—2
Nelson, Russell A., Johns Hopkins Hospital—5
Nesbitt, John A., Jr., 1118 St. Paul Street—2
Neubauer, Imre, 936 Patapsco Avenue—25
Ney, Grover C., 2401 Linden Avenue—17
Niblett, Walter S., 2220 Garrison Blvd.—16
Nichols, Firmadge K., 4711 Roland Avenue—10
Nitsch, Norbert C., 2151 Wilkins Avenue—23
Nolan, James, 5804 Edmondson Avenue—28
Norton, John Charles, Jr., 1933 W. Baltimore Street—23
Norwood, V. Hyatt, Church Home & Hospital—31
Novak, Edmund Rogers, 26 E. Preston Street—2
Novak, Eduard, Medical Arts Bldg.—1
Novak, Emil, 26 E. Preston Street—2
Nowak, Sigmund R., 408 S. Patterson Park Avenue—31

---

* Deceased.

O'Connor, John A., 11 E. Chase Street—2
O'Donovan, Charles, Jr., 3111 N. Charles Street—18
Ogden, Frank N., 2701 N. Calvert Street—18
O'Hare, James Stewart, 6 E. 30th Street—18
O'Rourk, Thomas R., 104 W. Madison Street—1
Osborne, John C., 3122 Northern Parkway—14
Otenasek, Frank J., 6 E. Eager Street—2
Owen, Arthur John, 1200 E. Belvedere Avenue—13
Owen, John Keller, 104 W. Madison Street—1
Owens, Ella Uhler, 1512 East 36th Street—18
Owens, William C., 1512 East 36th Street—18
Owings, James C., 18 W. Franklin Street—1
Ozazewski, John Casimir, 1540 Oakridge Road—18
Pacienza, Frank A., Medical Arts Building—1
*Padget, Paul, Veterans Administration Hospital, Fort Howard
Pair, James Mansfield, 400 N. Carrollton Avenue—23
Palese, John Michael, 11 E. Chase Street—2
Park, Edwards A., Pathological Building, Johns Hopkins Hospital—5
Park, William F., 52 Rowell Circle, Hancock Village, Havelock, N. C.
Parker, Robert T., 620 Wilton Road—Towson 4
Parrott, Frank Strong, 121 Orchard Street, Mt. Airy, N. C.
Parsons, John Warner, 11 E. Chase Street—2
Pass, I. Earl, 4001 Wilkins Avenue—29
Patt, Howard H., 803 Cathedral Street—1
Patton, Genieann Parker, 1726 Pin Oak Road—Towson 4
Patz, Arnall, 920 St. Paul Street—2
Paulson, Moses, 11 E. Chase Street—2
Peake, Clarence William, 4508 Harford Road—14
Pearce, William F., 2105 N. Charles Street—18
*Pearce, Wm. H., 2105 N. Charles Street—18
Peck, John Lyman, 5506 Lombardy Place—10
Peirce, E. Converse, 2nd, 4512 Marble Hall Road—12
Pembroke, Richard H., Jr., 1311 N. Calvert Street—2
Pendleton, George H., 1723 Druid Hill Avenue—17
Pessagno, Daniel J., Medical Arts Bldg.—1
Peters, H. Raymond, 1127 N. Calvert Street—2
Phelan, Patrick C., Jr., 239 Linden Avenue, Towson—4
Phelps, Winthrop Morgan, 3038 St. Paul Street—18
Phillips, Otto C., 2210 Erdman Avenue—13
Pierce, Leslie Harrall, 700 Cathedral Street—1
Pierpont, Ross Z., 111 W. Monument Street—1
Pierson, J. W., 1107 St. Paul Street—2
Pincoffs, Maurice C., University Hospital—1
Pines, Samuel R., The Latrobe Apartments—2
Pleasants, Jacob Hall, 201 Longwood Road, Roland Park—10
Pleet, Jerome, 7021 Alden Road—8
Polek, Melvin F., 4200 Sheldon Avenue—6
Polvogt, Leroy M., 1201 N Calvert Street—2
Porter, Harry P., 6473 Blenheim Road—12
Pound, John C., 4513 Old Frederick Road—29
Prager, Helmut, 1308 Eutaw Place—17
Pratt, Daniel Wells, Johns Hopkins Hospital—5
Pratt, Louis J., Jr., 8402 Greenway, Towson—4
Primakoff, H. William, Emersonian Apartments—17
Proctor, Donald F., Johns Hopkins Hospital—5
Proctor, Samuel Edward, 104 W. Madison Street—1
Pugh, Albert Ellsworth, Veterans Administration, Fort Howard, Md.
Putterman, Morris N., 2324 Reisterstown Road—17
Queen, J. Emmett, 4418 Norwood Road—18
Racusin, Nathan, 206 S. Gilmor Street—23
Radman, H. Melvin, Esplanade Apts., Eutaw Place & Brooks Lane—17
Raffel, William, 803 Cathedral Street—1
Ramsey, James H., 5711 Mineral Avenue, Halethorpe—27, Md.
Ramundo, Michael R., 89 Avondale Avenue, Clifton, N. J.
Randolph, M. Elliott, 11 E. Chase Street—2
Rangle, Raymond V., 642 Washington Boulevard—30
Raskin, Moses, 817 St. Paul Street—2
Rathbun, Howard K., Carroll Manor Road, Baldwin, Md.
Ratliff, Cliff, Jr., 4605 Edmondson Avenue—29
Reckling, Ralph Weeden, 520 N. Fulton Avenue—17
Reese, Fred M., 330 N. Charles Street—1
Reifschneider, Charles A., 104 W. Madison Street—1
Reifschneider, Herbert E., 104 W. Madison Street—1
Reiter, Robert A., 3408 Windsor Avenue—16
Renner, William F., 11 West 29th Street—18
Revell, Samuel T. R., Jr., 11 East Chase Street—2
Rich, Arnold R., Johns Hopkins Hospital—5
Rich, Benjamin S., Medical Arts Bldg.—1
Richards, Esther Loring, 41 W. Preston Street—1
Richardson, Edward H., 9 E. Chase Street—2
Richardson, Edward H., Jr., 9 E. Chase Street—2
Richardson, Horace K., 11 E. Chase Street—2
Richter, Christian F., 11 W. Biddle Street—1
Richter, Conrad Louis, 2237 Lake Avenue—13
Ridgely, Irwin O., 201 W. Madison Street—1
Rienhoff, William Francis, Jr., 1201 N. Calvert Street—2

---

* Deceased.

*Ries, A. Ferdinand, 302 Northway, Guilford—18
Rigler, Richard R., 1017 E. Baltimore Street—2
Riley, Eugene John, 2128 N. Calvert Street—2
Riley, Richard Lord, 1901 Dixon Road—9
Rinehart, Arthur M., 4823 Keswick Road—10
Rinn, William Alexander, Medical Arts Building—1
Rizika, Stuart D., 3411 Rosedale Road—15
Roach, Thomas Edward, 514 Drury Lane—29
Robbins, Martin A., 1801 Eutaw Place—17
Roberts, David P., 11 E. Chase Street—2
Robertson, J. Clagett, 117 S. Broadway—31
Robinson, Aaron, 1817 Eutaw Place—17
Robinson, Daniel R., V. A. Hospital, Ft. Howard—19
Robinson, Harry M., 106 E. Chase Street—2
Robinson, Harry M., Jr., 1024 N. Calvert Street—2
Robinson, Raymond C. V., 11 Murray Hill Circle—12
Robnett, Dudley Anderson, Jr., Medical Group, Palm Beach International Airport, West Palm Beach, Florida
Rochberg, Samuel, 2202 W. Rogers Avenue—15
Rodgers, William A., 815 Eastern Avenue—21
Roetling, Carl P., 1326 W. Lombard Street—23
Rogers, Harry L., 101 E. Preston Street—2
*Rohrer, Caleb W. G., 2814 Ailsa Avenue—14
Roman, Paul, 1810 Eutaw Place—17
Rombro, Marvin Jay, 913 E. Belvedere Avenue—12
Rosen, Harold, 1101 N. Calvert Street—2
Rosen, Israel, 2413 E. Monument Street—5
Rosenfeld, Morris, 3103 Bonnie Road—8
Rosenthal, Gilbert White, 1739 Eutaw Place—17
Rosenthal, Harry William, 1902 Greenmount Avenue—18
Rosin, John D., 1010 St. Paul Street—2
Rossberg, Clyde Arthur, 2436 Washington Boulevard—30
Rothholz, Alma S., Apt. 1-C, 822 Belgian Avenue—18
Rowland, James M. H., 1118 St. Paul Street—2
Rowland, William M., 5502 Huntley Square—10
Rubin, Samuel, 1109 N. Calvert Street—2
Rubin, Samuel, 203 Patapsco Avenue—25
Rubin, Seymour W., 2703 W. Belvedere Avenue—15
Rubinstein, Hyman S., 2349 Eutaw Place—17
Rudman, Gilbert E., 2517 W. Baltimore Street—23
Rudo, Alvin D., Latrobe Apartments—2
Russell, Thomas Edgie, 3901 N. Charles Street—18
Russo, James, 829 Kingston Road—12
Rutledge, Benj. Huger, 18 E. Eager Street—2
Ruzicka, F. Fred, 800 N. Patterson Park Avenue—5
Rysanek, William J., 801 N. Kenwood Avenue—5
Rysanek, William J., Jr., 1013 N. Calvert Street—2
*Rytina, Anton George, 5003 St. Albans Way—12
Sachs, Louis, Marlborough Apts.—17
Sacks, Milton S., University Hospital—1
Salik, Julian V., 3602 Clarinth Road—15
Sanderson, John W., 1714 N. Caroline Street—13
Sardo, Robert S., 303 Woodbourne Avenue—12
Sarubin, Benjamin, 2128 W. North Avenue—17
Sauber, Irvin, 3003 Garrison Boulevard—16
Saunders, LeRoy W., 216 Goodale Road—12
Savage, John Edward, Boyce Avenue, R.D. #8, Towson—4
Sawyer, George J., Jr., 4808 Harford Road—14
Sawyer, William H., Jr., 4928 West Hills Road—29
Saylor, Lloyd E., 3902 Greenmount Avenue—18
Sborofsky, Isadore, 4212 Oakford Avenue—15
Scagnetti, Albert, 1729 W. Lombard Street—23
Scarborough, Clarence P., Jr., 104 W. Madison Street—1
Schaefer, John F., 401 Random Road—29
Schaefer, Otto, 920 St. Paul Street—2
*Schaefer, Theodore A., 3610 Harford Road—18
Schaffer, Alexander J., 1109 St. Paul Street—2
Schapiro, Abraham, 2028 Eutaw Place—17
Schapiro, William B., 2415 Eutaw Place—17
Schenker, Paul, 2424 Eutaw Place—17
Scher, Ernest, 1701 Eutaw Place—17
Scher, Isadore, 2502 Eutaw Place—17
Scherlis, Irving, 2501 Overbrook Road—8
Scherlis, Leonard, 1214 N. Calvert Street—2
Scherlis, Sidney, 1214 N. Calvert Street—2
Scheurich, John A., 1337 S. Charles Street—30
Scheye, Henry W., 3921 Edmondson Avenue—29
Schiff, Hyman, 4023 Fallstaff Road—15
Schimek, Robert A., Johns Hopkins Hospital—5
Schimunek, Emanuel, 842 S. East Avenue—24
Schlesinger, George Gerard, 16 E. Biddle Street—2
Schmitz, William J., 118 Midhurst Road—12
Schneidmuhl, Abraham M., 3340 Dolfield Avenue—15
Schnitzer, Eugene, 3904 S. Hanover Street—25
Schochet, George, 1218 N. Calvert Street—2
Schoenrich, Herbert, Calvert & Preston Streets—2
Scholz, Roy O., 11 E. Chase Street—2
Schonfeld, Paul, 2301 Annapolis Road—30
Schreiber, M. B., 3506 Ellamont Road—15

---

* Deceased.

Schuman, William, 1716 Eutaw Place—17
Schwartz, Daniel J., 2320 Eutaw Place—17
Schwartz, Theodore A., 834 Park Avenue—1
Schwentker, Francis F., 209 Tunbridge Road—12
Scott, Eleanor, 1014 St. Paul Street—2
Scott, John M., 8 Longwood Road—10
Scott, William Wallace, Rider Hill Road, Ruxton—4
Seegar, J. King B. E., Jr., 3714 Winterbourne Road—16
Seidel, Henry Murray, 3119 Bancroft Road—15
Seidel, Herman, 2404 Eutaw Place—17
Seliger, Robert V., 2030 Park Avenue—17
Serra, Lawrence M., 11 E. Chase Street—2
Settle, William Booth, 126 Homeland Avenue—12
Shackelford, Richard T., 18 E. Eager Street—2
Shamer, Maurice E., 3300 W. North Avenue—16
Shanahan, Daniel S., 1945 W. Baltimore Street—23
Shannon, George E., 100 St. Johns Road—10
Shapiro, Albert, 1109 N. Calvert Street—2
Sharfatz, George, 5106 Park Heights Avenue—15
Shaw, Charles E., 5801 Loch Raven Boulevard—12
Sheehan, Joseph Chester, 11 E. Chase Street—2
Shell, James H., Jr., Medical Arts Building—1
Sheppard, Henry, Jr., 922 W. University Parkway—10
Sheppard, Robert C., Medical Arts Bldg.—1
Shepperd, J. Douglass, 604 N. Fulton Avenue—17
Sherman, Jerome, 2502 Eutaw Place—17
Sherman, Solomon, 2424 Eutaw Place—17
Sherman, Harry Donald, 2326 Eutaw Place—17
Sherry, Milton, 11 E. Chase Street—2
Shervington, E. Walter, U. S. Army Hospital, Ft. Bragg, N. C.
Shiling, Moses Samuel, 2426 Eutaw Place—17
Shimanek, Lawrence J., 1 South Wind Court, Ruxton—4
Shipley, Arthur Marriott, 507 Edgevale Road, Roland Park—10
Shipley, Edgar Roderick, Medical Arts Building—1
Shpritz, Nathan H., 3100 Garrison Boulevard—16
Shochat, Albert J., 4111 Liberty Heights Avenue—7
Shub, Maurice I., 135 Berteau Avenue, Elmhurst, Illinois
Shulman, Leon M., 6715 Park Heights Avenue—15
Siegel, Isadore A., 2309 Eutaw Place—17
Silberman, David, 1411 Eutaw Place—17
Silver, A. A., Temple Garden Apartments—17
Sima, Charles Edward, 2074 E. Belvedere Avenue—14
Sindler, Joseph, 929 Brooks Lane—17
Singewald, Albert G., 1613 E. North Avenue—13
Singewald, Martin Louis, 11 E. Chase Street—2
Sinsky, H. L., 310 E. North Avenue—2
Sisco, P. S. Bourdeau, 2500 Garrison Blvd.—16
Siscovick, Milton, 1429 W. Fayette Street—23
Siver, Robert H., 3105 N. Charles Street—18
Siwinski, Arthur George, 15 E. Biddle Street—1
Siwinski, Thaddeus Charles, 807 Wellington Road—12
Skillman, Wilbur F., 6 E. Biddle Street—2
Skloven, Joseph, 7122 Harford Road—14
Slack, Harry R., Jr., 1100 N. Charles Street—1
Sloan, Robert D., Johns Hopkins Hospital—5
Slockbower, Edith Treptow, 901 Cathedral Street—1
Small, Mary Louise, 16 W. Read Street—1
Smink, Claude, St. Michaels, Md.
Smith, D. C. Wharton, 2nd, 2 Wyndhurst Avenue—10
Smith, E. P., 920 St. Paul Street—2
Smith, E. P., Jr., 20 Fernald Drive, Suite 11, Cambridge 38, Mass.
Smith, Frank R., Jr., 623 W. University Pkwy.—10
Smith, Frederick Bruce, 11 E Chase Street—2
Smith, Harry Bryant, 1201 Oxford Road—12
Smith, Howard Chandler, Medical Arts Bldg.—1
Smith, John Prinz, 1100 E. Belvedere Avenue—12
Smith, Olive Cushing, 20 W. Madison Street—1
Smith, Ruby A., 513 N. Charles Street—1
Smith, Sol, 2426 Eutaw Place—17
Smith, William Henry, 3429 Chestnut Avenue—11
Smith, Winford H., 100 W. University Parkway—10
Snyder, Jerome, 11 E. Chase Street—2
Snyder, Nathan, 1200 St. Paul Street—2
Snyder, Samuel, 1634 E. Baltimore Street—31
Sodaro, Manuel, 826 E. Belvedere Avenue—12
Sollod, Aaron C., 707 E. Fort Avenue—30
Solomon, Milton L., 129 S. Broadway—31
Sondheimer, A. Adler, Esplanade Apts.—17
Spear, Irving J., 928 N. Charles Street—1
Speed, William G., III, 11 E. Chase Street—2
Spelsberg, Walter K., 903 Pemberton Road—12
Spence, John Morland, Jr., 2903 N. Charles Street—18
Spier, Andrew Allan, 4408 Loch Raven Boulevard—18
Spitzberg, Randolph Howard, 5010 Denmore Avenue—15
Sprunt, Katherine, 4407 Norwood Road—18
Sprunt, T. P., 1035 N. Calvert Street—2
Spurrier, O. Walter, 3603 Edmondson Avenue—29
Stacy, Theodore E., Jr., 319 St. Dunstans Road—12
Stafford, Edward S., 11 E. Chase Street—2
Stebbins, Ernest L., 615 N. Wolfe Street—5
Stedem, Anthony F. A., Jr., V. A. Hospital, Perry Point, Md.

Steinbach, Stanley R., 3334 Dolfield Avenue—15

Steinberg, Morris William, 410 N. Hilton Street—29

Steinberg, Murray, 3306 Springdale Avenue—16

Steiner, Albert, 1308 Eutaw Place—17

Stevens, Leland B., 3400 Erdman Avenue—13

*Stevens, Thomas F. A., 2878 Harford Road—18

Stewart, Charles Wilbur, 6 E. Read Street—2

Stewart, Edwin Henry, Jr., Medical Arts Bldg.—1

Stewart, George A., 3301 N. Charles Street—18

Stewart, William Lewis, Baltimore City Hospitals—24

Stickel, Frederick L., 111 Arbutus Avenue-Eden Terrace—28

Stickney, Geo. L., The Latrobe—2

Stifler, Jean Rose, 3301 N. Charles Street—18

Stifler, William Curtis, Jr., 3301 N. Charles Street—18

Stiles, Cleo D., Jr., Medical Arts Bldg.—1

Stinson, Edward, Jr., 18 E. Eager Street—2

Stone, Douglas H., 2921 St. Paul Street—18

Stone, Harvey Brinton, 18 W. Franklin Street—1

Stout, Merrell L., Hospital for the Women of Maryland—17

Styrt, Jerome, Dept. of Psychiatry, University of Maryland School of Medicine—1

Suarez-Murias, Edward L., 11 E. Chase Street—2

Sullivan, Maurice, 11 E. Chase Street —2

Sullivan, Sullins G., 1129 St. Paul Street—2

Sullivan, William Joseph, 11 E. Chase Street—2

Summers, Henry G., 300 Church Street, Brooklyn

Sunday, Stuart D., 201 E. 33rd Street —18

Supik, William Joseph, 1127 St. Paul Street—2

Supplee, J. Frank, III, 1014 St. Paul Street—2

Sussman, Abraham Allen, 1109 N. Calvert Street—2

Sutley, Percy H., 411 Chestnut Avenue, Towson—4

Swiss, Adam G., 6232 Belair Road—6

Tanenbaum, Solomon, 1250 E. North Avenue—2

Tankin, Louis H., 3717 Nortonia Road—16

Tansey, John J., The Latrobe Apartments—2

Tappan, Benjamin, 1201 N. Calvert Street—2

Taussig, Helen B., Johns Hopkins Hospital—5

Taylor, Robert B., 700 Cathedral Street—1

Teagarden, Ersie V., 603 Club Road —10

Teitelbaum, Harry Allen, 1801 Eutaw Place—17

Te Linde, Richard Wesley, The Johns Hopkins Hospital—5

Tenner, David, 3505 Ellamont Road —15

Thomas, Anthony J., 4600 York Road —12

Thomas, Caroline Bedell, 700 N. Wolfe Street—5

Thomas, Clyde Dana, Jr., 1412 Regester Avenue—12

Thomas, Henry M., 314 Overhill Road—10

Thompson, Raymond Kieff, 11 E. Chase Street—2

Tiemeyer, Arthur Charles, 101 W. Monument Street—1

Tilghman, R. Carmichael, 6 E. Eager Street—2

Tillman, Richard Nelson, 3035 St. Paul Street—18

Tinker, Francis X. P., 1500 Manning Road—23

Todd, Homer U., 2108 St. Paul Street —18

Toll, Karel v.S., 3614 Eastwood Drive—6

Tommasello, Charles, Jr., 910 W. Lombard Street—23

Tompakov, Samuel Victor, 3600 Park Heights Avenue—15

Tonolla, E. Howard, The Latrobe Apartments—2

Touhey, T. Jos., 441 S. Ellwood Avenue—24

Toulson, W. Houston, Medical Arts Bldg.—1

Tower, Sarah Sheldon, 11 E. Chase Street—2

Townshend, Wilfred H., Jr., 6 St Georges Road—10

Traband, John H., Jr., 1219 Poplar Grove Street—16

Traband, Millard T., Jr., 3400 Woodbine Avenue—7

Tramer, Arnold, Baltimore City Hospitals—24

Traugott, Karl, 1912 E. Belvedere Avenue—14

Traynor, Francis W., 901 St. Paul Street—2

Trescher, John H., 1035 N. Calvert Street—2

Trimble, I. Ridgeway, 8 W. Madison Street—1

Truitt, Ralph P., 1118 St. Paul Street —2

Tuminello, Salvatore Anthony, Medical Arts Bldg.—1

Tunney, Robert B., 115 E. Eager Street—2

Turner, Thomas B., 615 N. Wolfe Street—5

Ullman, Alfred, 1712 Eutaw Place—17

Ullrich, Henry Franz, 804 Cathedral Street—1

Ullsperger, John F., Apt. E, 1641 Waverly Way—12

Urlock, John P., 3700 Garrison Bldg. —15

Van Lill, Stephen J., 205 N. Rolling Road—28

Vanni, Frank L., 11 E. Chase Street —2

Vest, Cecil W., 1014 St. Paul Street —2

Vinup, Frederick H., 110 E. Lombard Street—2

Vogel, Louis, Jr., 2601 E. Monument Street—5

Vollmer, Frederick J., 311 E. Gittings Avenue—12

Von Schulz, Augustine P., 4818 Edmondson Avenue—29

Voshell, Allen Fiske, Medical Arts Bldg.—1

Vozel Luther F., 3105 N. Charles Street—18

Vyner, Harold L., 817 St. Paul Street —2

Wack, Frederick V. D., 513 E. 39th Street—18

Waghelstein, Julius M., 803 Cathedral Street—1

Wagley, Philip Franklin, 9 E. Chase Street—2

---

* Deceased.

Wainwright, Charles W., 9 E. Chase Street—2

Walden, Emerson C., Sr., Provident Hospital—17

Walker, A. Earl, 601 N. Broadway—5

Walker, Wm. Wallace, Medical Arts Bldg.—1

Wall Lester Aubrey, Jr., 4407 Underwood Road—18

Wallenstein, Leonard, 848 W. 36th Street—11

*Wallenstein, Sydney, 2042 Eutaw Place—17

Waller, W. Kennedy, 512 Cathedral Street—1

Walsh, Frank Burton, 12 W. Read Street—1

Walton, Henry J., Medical Arts Bldg. —1

Ward, Arthur T., 116 Taplow Road —12

Ward, Grant E., 15 E. Biddle Street —2

Warner, Chas. Luther, 3312 Egerton Road—15

Warner, Howard H., 2604 Garrison Avenue—16

Warres, Herbert Leonard, 2337 Eutaw Place—17

Wasserman, Harry 1501 Eutaw Place —17

Waters, Charles A., 1100 N. Charles Street—1

Watson, George Smith, Walnut Avenue, Riderwood, Md.

Webster, Thomas Clyde, 4336 N. Charles St.—18

Weeks, William Earl, 5839 York Road —12

Wehner, Daniel George, Medical Arts Bldg.—1

Weinberg, Edwin David, Latrobe Apts.—2

Weinberg, Harold H., 1724 Eutaw Place—17

Weinberg, J. Arthur, Latrobe Apartments—2

Weinberg, M. A., 1724 Eutaw Place —17

Weinberg, Tobias, 3700 Kingwood Square—15

Weinberger, Richard, 912 Brooks Lane—17

Weinstock, Alexander A., 4603 Park Heights Avenue—15

*Weisman, Samuel, 4004 Liberty Heights Avenue—7

Weiss, Albert J., 4115 W. Rogers Avenue—15

Weitzman, Elliott L., 6018 Clover Road—15

Welch, Hugh J., 1123 St. Paul Street —2

Welcome, Henry C., 1131 Harlem Avenue—17

Welfeld, Alvan A., 1801 Eutaw Place —17

Wells, Geo. E., 4100 Edmondson Avenue—29

Wells, George Edward, Jr., 1000 Wildwood Parkway—29

Wells, Gibson Jackson, 3101 St. Paul Street—18

Wells, John Bernard, Jr., 6007 Sycamore Road—12

West, Arthur M., 2411 Mosher Street —16

Wexler, Jack, 2502 Eutaw Place—17

Wharton, Lawrence R., 1201 N. Calvert Street—2

Wharton, Lawrence R., Jr., 4504 Roland Avenue—10

Whedbee, James S., Jr., 18 E. Eager Street—2

White, James Edmond, 5214 Harford Road—14

*White, Thomas F., 3809 Greenmount Avenue—18

White, William Kelso, 3005 St. Paul Street—18

Whitehorn, John C., Johns Hopkins Hospital—5

Whitehouse, Samuel, 1720 Eutaw Place—17

Whitham, Lloyd B., 806 Cathedral Street—1

Whitridge, John, Jr., 2411 N. Charles Street—18

Whittle, Henry Lyman, 1229 N. Calvert Street—2

Wice, Louis Ervine, 920 St. Paul Street—2

Wich, Joseph Carlton, 1637 Stonewood Road—12

Wieciech, Michael J., 707 S. Ann Street—31

Wies, David, 1613 Waverly Way —12

Wilder, Earle M., 1719 Eutaw Place —17

Wilder, Milton J., 1719 Eutaw Place —17

Wilfson, Daniel, Jr., 5721 Park Heights Avenue—15

Wilgis, Herbert E., 2947 St. Paul Street—18

Wilkerson, Albert Russell, 1200 St. Paul Street—2

Wilkins, Lawson, 501 Edgevale Road —10

Wilkinson, William Emmet, Jr., 609 Cathedral Street—1

Will, David Reid, 3619 Lochearn Drive—7

Williams, H. Maceo, 201 N. Carey Street—23

Williams, Huntington, 620 W. Belvedere Avenue—10

Williamson, Charles Vernon, 201 Huron Road, Catonsville—28

Williamson, Edgar P., II, 201 Hilton Avenue—28

Willson, James Knox VanArsdale, 8211 Loch Raven Blvd.—4

Wilson, Harry E., 3 W. Biddle Street —1

Wilson, Harry Thomas, Jr., 1204 St. Paul Street—2

Wilson, Henry Beatty, U. S. Air Force Hospital, % P.M., Seattle, Washington

Wilson, Marion Evans, 803 W. Fremont Avenue—17

Wing, Wilson M., 615 N. Wolfe Street —5

Winkenwerder, Walter L., 1014 St. Paul Street—2

Wise, Walter Dent, 1120 St. Paul Street—2

Witt, John Philip, The Latrobe Apartments—2

Wolf, Frederick S., 150th Medical Group, APO 226, % P.M., San Francisco, Cal.

Wolf, Nathan, Box 367, Westmorland, Calif.

Wolfe, Samuel B., 1331 E. North Avenue—13

Wolff, Thomas Conrad, 11 E. Chase Street—2

Wolins, Allan Yale, 902 Patapsco Avenue—25

Wollenweber, Henry L., Medical Arts Bldg.—1

Wolman, Samuel, 2424 Eutaw Place —17

Woltereck, G. H., 10 E. Biddle Street —2

Wood, Austin H., Medical Arts Bldg. —1

---

* Deceased.

Woodland, Charles T., 861 Harlem Avenue—17
Woodruff, James Donald, 6 E. Eager Street—2
Woods, A. C., Wilmer Institute—5
Woods, Alan C., Jr., 11 E. Chase Street—2
Woodward, Theodore E, 1 Merrymount Road—10
Woody, W. H., 1403 Park Avenue—17
Worden, Frederic G., Sheppard and Enoch Pratt Hospital—4
Workman, Joseph B., 101 S. Bellegrove Road—28
Worsley, Thomas L., Jr., 2900 Alameda Blvd.—18
*Wright, H. E., Medical Arts Bldg.—1
Wright, Robert B., Medical Arts Bldg.—1
Yaffe, Kennard, 3101 W. Baltimore Street—29
Yaffe, Stanley Norman, 3847 Forest Park Avenue—16
Yeager, George H., Medical Arts Bldg.—1
York, James Arthur, 1101 N. Calvert Street—2
Young, Asa Dougal, 20 E. Preston Street—2
Young, Betty May, 1214 Eutaw Place—17
Young, John David, Jr., 11 E. Chase Street—2
Young, Latimer G., 313 Tunbridge Road—12
Young, Leroy J., 130 W. Kingbridge Road, Bronx 68, N. Y.
Young, N. Louise, 1100 Druid Hill Avenue—17
Young, Ralph J., 1429 E. Monument Street—5
Zeligman, Israel, 1109 N. Calvert Street—2
Zepp, Herbert Elmo, 3400 Windsor Avenue—16
Zheutlin, Harold E. C., 1112 N. Calvert Street—2
Ziegler, Paul R., 3723 Edmondson Avenue—29
Zierler, Joseph N., 2318 Eutaw Place—17
Zierler, Kenneth L., 4004 Alto Road—16
Zimmerman, Loy M., 2858 Harford Road—18
Zinberg, Israel Saul, 2320 Eutaw Place—17
Zinn, Waitman F., Medical Arts Bldg.—1
Zupnik, Howard L., 427 Hopkins Road, Rodgers Forge—12

Associate Members

Abraham, Robert Auman, 1712 Aberdeen Road—4
Amberson, William R., Cockeysville
Bair, Robert C., Apt. B., 1637 Waverly Way—12
Bell, William Harrison, Jr., Route 1, Box 78, New Bern, N. C.
Bernstein, Milton, 3302 Clarks Lane—15
Boyd, Joseph Alston, Dept. of Radiology, Duke Hospital, Durham N. C.
Brailey, Miriam E., Harriet Lane Hospital—5
Brambel, Charles E., 1504 Park Avenue—17
Buettner, Henry F., 5005 Edmondson Avenue—29
Chandler, Caroline A., 615 N. Wolfe Street—5
Clark, Fred Harlow, 3610 Gwynn Oak Avenue—7
Coles, John Howard, III, Baltimore City Hospitals—24
Cowley, R. Adams, 907 Belgian Avenue—18
Cullison, Robert M., 925 Shober Street, Winston-Salem, N. C.
Cunnick, Dorothy Gildea, Baltimore City Hospitals—24
Cunnick, Paul Carrollton, 422 Bonsal Street—24
Dana, George William, 6202 Sycamore Road—12
Davies, Edward Ross, 505 Radnor Avenue—12
Davis, Joseph Wilfred, 326 Radnor Road—12
Evans, John E., 1724 Reisterstown Road, Pikesville—8
Finberg, Lawrence, 4702 Wakefield Road—16
Fink, Arthur I., 724 W. North Avenue—17
Fishburn, Howard D., U. S. Marine Hospital—11
Fleck, Warren L., Veterans Admistr., Fort Howard
Frankel, Samuel S., 2022 W. Rogers Avenue—15
Freeman, Irving J., Veterans Administration Hospital, Fort Howard, Md.
Gantt, William Horsley, Johns Hopkins Hospital—5
Gladue, J. Raymond, VA Hospital, Fort Howard—19
Goehrs, Homer R., USS Albany, ℅ FPO, N. Y., N. Y.
Goldsmith, Harry, 3023 Hanlon Avenue—16
Gould, David M., 3403 Calloway Avenue—15
Graves, Joseph, Baltimore City Hospitals—24
Griffith, Paul Condon, Dept. Pathology, Johns Hopkins Hospital—5
Griffey, Walter P., U. S. Public Health Service Hospital—11
Hartman, Robert Carl, 1111 Brookmeade Drive, Nashville, Tenn.
Hauber, Frank D., Harford Memorial Hospital, Havre de Grace, Maryland
Hawkins, Charles W., U. S. A. Hospital, Fort Benning, Ga.
Hingson, Robert Andrew, 2889 N. Park Blvd., Cleveland Heights, Ohio
Jensen, Jacob Roed V. A. Hospital—18
Johnson, J. Paul, Jr., 812 E. Wilson Point Road—20
Kac, Arthur, 2405 Garrison Blvd.—16
Kalish, John T., 1731 Waverly Way—12
Kanner, Leo, 4510 Wentworth Road—7
Katz, Albert H., 3855 Forest Park Avenue—16
Katzenelbogen, Solomon, Suite 314 Eig Bldg., 8641 Colesville Rd. Silver Spring, Md.
Kernahan, William Tallmadge, Jr., 1938 Estes Avenue, Chicago 26, Ill.
Kirkpatrick, Wendell Charles, 1329 Broadway, Longview, Wash.
Knox, Lawrence Joseph, 418 S. Elliott Street, Olney, Ill.
Krantz, John C., Ellenham Road, Ruxton—4
Kuntz, David H., 3169 S. Sepulveda Blvd., Los Angeles 34, Calif.
Lansdowne, Milton, 6101 Stuart Avenue—9
Larkey, Sanford Vincent, Welch Medical Library—5

---

* Deceased.

Lattimore, Thomas, Baltimore City Hospitals—24

Levi, Ernest, 3717 Park Heights Avenue—15

Lippman, Eli Morton, U. S. Public Health Service Hospital—11

McDonnell, Peter J., 1710 Freedomway, North—13

MacGibbon, John Butler, 954 Forest Street—2

MacGowan, Birkhead, 11 E. Read Street—2

Mandell, Sibyl, Division of Mental Hygiene, Baltimore City Health Department—3

Marshall, Alice Berry C., 701 Cathedral Street—1

Marshall, E. Kennerly, 701 Cathedral Street—1

Martin, Clarence W., 1078 Cameron Road—12

Nelson, Nels A., 4228 Kelway Road —18

Notkin, Herbert, 4306 Liberty Heights Avenue—15

Nussbaum, Kurt, 207 Clarendon Avenue, Pikesville—8

Parelhoff, Merrill Elliott, 903 Lake Drive—17

Polley, Virgil Britton, U. S. Public Health Service Hospital—11

Reimann, Dexter Leroy, 2504 Creighton Avenue—14

Richter, Curt Paul, The Johns kins Hospital—5

Robinson, G. Canby, 100 W. University Parkway—10

Roth, Merall, Galden Clinic and Memorial General Hospital, Elkins, W. Va.

Rudin, Louis N., Veterans Administration Hospital, Fort Howard, Md.

Rushmore, Stephen, 853 W. University Parkway—10

Scott, Roger David, University Hospital—1

Silverman, Charlotte, 705 Municipal Bldg—1

Smith, George Williams, Johns Hopkins Hospital—5

Spencer, Hugh R., University Hospital—1

Spicknall, Charles, U. S. Public Health Service Hosp.—11

Tasker, Arthur N., 317 Tuscany Road—10

Terry, Luther L., U. S. Public Service Hospital—11

Tidler, Harold S., VA Hospital, Lanham, Md.

Trimble, Frances Hartley, 6006 Charlesmeade Road—12

Tull, Myron G., 426 E. Lake Avenue —12

Vande Grift, William B., 211 Ridgemede Road 10

Van Woert, Irving, Jr., M. S. Public Health Hospital, Box 108, Staten Island 4, N. Y.

Wagner, John Alfred, 3419 Guilford Terrace—18

Warner, C. Gardner, 7115 Bristol Road—12

Wolfson, Justin J., 4005 Cedardale Road—15

Wylie, H. Boyd, 3119 N. Calvert Street—18

Baltimore County

Allison, Robert Herschel, 4 York Road, Towson 4, Md.

Andrew, David Holmes, 5410 Willowmere Way, Baltimore 12, Md.

Armacost, Joshua H., 6419 Windsor Mill Road, Woodlawn 7, Md.

Bacon, A. M., 2810 Taylor Avenue, Parkville 14, Md.

Baier, John C., 160 Stemmers Run Road, Baltimore 21, Md.

Barstow, Mary V. M., Owings Mills, Md.

Baumgardner, George M., 2552 Philadelphia Road, Baltimore 6, Md.

Beck, Irving R., 901 Fuselage Avenue, Baltimore 20, Md.

Beitler, Frederic V., Medical Arts Building, Baltimore 1, Md.

Benson, Edward H., 1 W. Overlea Avenue, Baltimore 6, Md.

Block, Nathan, 6200 Verdene Avenue, Baltimore 9, Md.

Bociek, Stanley, 906 C Street, Sparrows Point, Baltimore 19, Md.

Bridges, William A., Otho Ridge Road, Towson 4, Md.

Brown, Lida Crockett, 528 Wyanoke Avenue, Baltimore 18, Md.

Brown, Seymour M., 1091 N. Canyon Drive, Palm Springs, Calif.

Bubert, John D., Wyman Park Apartments, Baltimore 11, Md.

Burns, Harold Hubert, 115 E. Eager Street, Baltimore 2, Md.

Burns, John Howard, Jr., 59 Dundalk Avenue, Dundalk 22, Md.

Burton, Charles H., 225 Northway, Baltimore 18, Md.

Butler, Harry G., Rosewood Training School, Owings Mills, Md.

Cameron, Joseph J., 23 A-Oak Grove Drive, Baltimore 20, Md.

Caples, D. Delmas, 6 Hanover Road, Reisterstown, Md.

Carmine, Walter M., 88 Baltimore Avenue, Dundalk 22, Md.

Carroll, Douglas Gordon, Jr., Brooklandville, Md.

Chance, Lester, 11 E. Chase Street, Baltimore 2, Md.

Cianos, James Nicholas, 1225 N. Calvert Street, Baltimore 2, Md.

Clarke, Sydenham Rush, E. Morris Avenue, Lutherville, Md.

Cooper, Donald D., 100 Burke Avenue, Towson 4, Md.

Cushing, Jean George N., 2 E. Read St., Baltimore 2, Md.

Cushing, Mary McK., 2 E. Read St., Baltimore 2, Md.

Dalmau, Louis Z., 1413 Reisterstown Road, Pikesville 8, Md.

Daugharthy, A. Bradley, 1264 Francis Avenue, Halethorpe 27, Md.

Daugharthy, Roselva T., 1264 Francis Avenue, Halethorpe 27, Md.

Dausch, Michael J., 4636 Belair Road, Baltimore 6, Md.

Davens, Edward, 2411 N. Charles Street, Baltimore 18, Md.

Davis, George H., 404 Hollen Road, Baltimore 12, Md.

Davis, Melvin B., 2910 Dunleer Road, Baltimore 22, Md.

D'Elia, Laurence N., 121 Forest Avenue, Catonsville 28, Md.

Depner, Rudolph, 114 Forest Drive, Catonsville 28, Md.

Dunton, William R., 33 N. Symington Road, Catonsville 28, Md.

Eichert, Arnold H., Crownsville State Hospital, Crownsville P. O., Md.

Ensor, Charles B., 7201 York Road, Baltimore 12, Md.

Estep, Paul R., 11770 Saratoga Avenue, Saratoga 1, Calif.

Evans, Eugene R., 1 Liberty Parkway, Dundalk 22, Md.

Farber, Dawson L., 914 D. Street, Sparrows Point 19, Md.

Farber, Mary S., 914 D. Street, Sparrows Point 19, Md.

Farber, Robert E., 914 D. Street, Sparrows Point 19, Md.

Ferris, Charles, U.S.A.F., 2 Columbia Ave., Greenville, Pa.

Fleischman, Gertrude J., Spring Grove Hospital, Catonsville 28, Md.
Flick, Elliott C., 108 Edgewood Road, Towson 4, Md.
France, A. M., Parkton, Md.
Gallager, Wilmer K., 6209 Frederick Avenue, Catonsville 28, Md.
Gill, Hugh C. F., 3710 Buckingham Road, Baltimore 7, Md.
*Glantz, Frank A., 7 Wendover Road, Baltimore 18, Md.
Gonzalez, Caridad E., 2911 Emerald Avenue, Baltimore 14, Md.
Goodman, William, 1334 Sulphur Spring Road, Arbutus 27, Md.
Grau, Edward Gordon, 8523 Loch Raven Boulevard, Towson 4, Md.
*Green, John S., Jr., Towson 4, Md.
Greenberg, Harold A., Sheppard-Pratt Hospital, Towson 4, Md.
*Gundry, Alfred T., Athol, Md.
Halperin, Herman J., Bethlehem Steel Co , Sparrows Point 19, Md.
Hammett, Walter M., Baldwin, Md.
Harris, Earle Warfield, 202-A. Donnybrook Lane, Towson 4, Md.
Hening, R. M., 203 Ingleside Avenue, Baltimore 28, Md.
Hetherington, Leon, 12 Darnell Road, Ruxton 4, Md.
Hiller, Grace, 401 Brook Road, Towson 4, Md.
Hills, Arthur Gorman, 228 S. Quince Street, Philadelphia, Pa.
Hollander, Mark, 817 St. Paul Street, Baltimore 2, Md.
Howell, Clewell, 102 Alleghany Avenue, Towson 4, Md.
Howell, James G., 715 Frederick Avenue, Catonsville 28, Md.
Hudson, Clifford F., Fork, Md.
Hudson, Rollin C., 606 Baltimore Avenue, Towson 4, Md.
Hyde, Robert T., Baltimore Co. Health Dept., Towson 4, Md.
Johns, George A., State Hospital, Farmington, Missouri
Johns, Viola B., Rosewood Training School, Owings Mills, Md.
Johnson, S. Lloyd, 6348 Frederick Road, Baltimore 28, Md.
Johnson, Warren C., 4291 Sixth St., S.E., Washington 20, D. C.
Junk, Ivan DeKalb, Randallstown, Maryland
Kees, Walter T., Cockeysville, Md.
Kenworthy, Richard Albert, III, Locust Avenue, Ruxton 4, Md.
Kerr, Charles M., 6801 Belair Road, Baltimore 6, Md.
Kieffer, George S., 1010 Leeds Avenue, Baltimore 29, Md.
Kolodny, A. L., 6023 Highgate Drive, Baltimore 15, Md.
Landau, Walter S., 23 Hanover Road, Reisterstown, Md.
McClinton, Isabel H., Kingsville, Md.
*McCormick, G. Carville, Sparrows Point, Md.
McGrath, William Edward, 104 Smithwood Avenue, Catonsville 28, Md.
Magness, Stephen L., 908 Frederick Avenue, Catonsville 28, Md.
Martin, William E., Randallstown, Md.
Mason, James R., Box 516, Mt. Hays, Md.
Matthews, Mary, Balto. Co. Health Dept., Towson 4, Md.
Means, James Thomas, 514 C. Street, Sparrows Point 19, Md.
Medairy, George C., Rosewood Training School, Owings Mills, Md.
Merrill, George G., Baldwin, Md.
Miceli, Joseph, 422 Eastern Avenue, Baltimore 21, Md.
Miller, James Alton, Reisterstown Road & Walker Avenue, Pikesville 8, Md.
Morrison, W. Herbert, 3 Kinship Road, Dundalk 22, Md.
Mund, Maxwell H., 417½ Eastern Avenue, Essex 21, Md.
Murdock, Harry Merrill, Sheppard-Pratt Hospital, Towson 4, Md.
Nevy, Eugene Francis, 7001 Mornington Road, Dundalk 22, Md.
Newcomer, William, Mt. Wilson, Md.
Newell, H. Whitman, 601 W. Lombard Street, Baltimore 1, Md.
Nichols, Elijah, 1402 Reisterstown Road, Pikesville 8, Md.
Nichols, Joseph Harold, 747 S. Avondale Road, Baltimore 22, Md.
Novey, Samuel, 11 E. Chase Street, Baltimore 2, Md.
O'Donnell, Charles Francis, 7301 York Road, Baltimore 4, Md.
Parr, William A., The Latrobe Apartments, Charles & Read Streets, Baltimore 2, Md.
Parson, Willard S., 1711 Selma Avenue, Halethorpe 27, Md.
Patton, John S., Sheppard & Enoch Pratt Hospital, Towson 4, Md.
Perkins, Clifton T., 646 Charles Street, Towson 4, Md.
Pierpont, Edwin L., 8027 Liberty Road, Baltimore 7, Md.
Post, Lawrence C., 6805 York Road, Baltimore 12, Md.
Pound, John Costello, 104 N. Rolling Road, Baltimore 28, Md.
Reese, J. Morris, Lutherville, Md.
Rehberger, John M., 10th Field Hospital APO 800 ℅ P.M., New York, N. Y.
Rier, Charles H., Dunkirk and York Roads, Anneslie 12, Md.
Richards, C. Victor, 321 Dunkirk Road, Baltimore 12, Md.
Riley, Robert H., 100 N. Beechwood Avenue, Baltimore 28, Md.
Roberts, Dean W., 811 Trafalgar Road, Towson 4, Md.
Roop, Donald, 3810 Oak Avenue, Baltimore 7, Md.
Royer, Earl L., 01724810 Mash 8076-AV, APO 301 ℅ P.M., San Francisco, Calif.
Royse, Paul H., 718 Cliveden Road, Pikesville 8, Md.
Runkel, John G., 29 Prospect Avenue, Baltimore 28, Md.
Saffell, James Glenn, 64 Main Street, Reisterstown, Md.
Sanner, J. Everett, 2032 Park Avenue, Baltimore 17, Md.
Sargent, George F., Aigburth Road, Towson 4, Md.
Sauer, Elmer, Mt. Wilson, Md.
Scalia, Samuel, 717 Howard Road, Baltimore 8, Md.
Seabold, William Merven, 5402 Edmondson Avenue, Carroll Station, Baltimore 29, Md.
Sedlack, Joseph Arthur, 200 W. Pennsylvania Avenue, Towson 4, Md.
Shanahan, Eugene R., 413 Eastern Avenue, Essex 21, Md.
Shear, Joseph, 805 Fuselage Avenue, Baltimore 20, Md.
Sherrill, Elizabeth B., Cockeysville, Md.
Siegel, Benjamin I., 15 Greenwood Road, Pikesville, Md.

---

* Deceased.

Smink, A. C., 701 W. Joppa Road, Towson 4, Md.
Sollod, Bernard Walter, 8 Liberty Parkway, Dundalk, 22, Md.
Somerville, Donald L., 24 Pennsylvania Avenue, Towson 4, Md.
Spragins, Melchijah, 102 Alleghany Avenue, Towson 4, Md.
Strobel, Martin, 59 Hanover Road, Reisterstown, Md.
Sugarman, Maxwell, Timbergrove Road, Owings Mills, Md.
Thomas, Joseph Henry, 8134-A, Bullneck Road, Dundalk 22, Md.
Thomas, Ramsay B., 4207 Frederick Avenue, Baltimore 29, Md.
Tollin, Louis M., 6908 North Point Road, Sparrows Point 19, Md.
Torrey, Eugene W., Granite, Md.
Tuerk, Isadore, Spring Grove State Hospital, Catonsville 28, Md.
Urban, George Edward, 803 Frederick Road, Catonsville 28, Md.
Wade, William C., 140 Oak Avenue, Dundalk 22, Md.
Ward, Charles, Rosewood Hospital, Owings Mills, Md.
Warthen, William H. F., 611 Hillen Road, Towson 4, Md.
Wheeler, H. Lawrence, 9 Paradise Avenue, Catonsville 28, Md.
Wheeler, Thomas E., Liberty & Cliftmar Roads, Randallstown, Md.
Whitehead, Hugh G., Jr., 1201 N. Calvert Street, Baltimore 2, Md.
Wilkinson, A. L., St. Michaels, Md.
Williams, Charles Herman, 1632 Reisterstown Road, Pikesville 8, Md.
Williams, Palmer F. C., 1725 Reisterstown Road, Pikesville 8, Md.
Windsor, Roger Gilbert, 520 D. Street, Sparrows Point 19, Md.
Zalis, Daniel, 1115 N. Calvert Street, Baltimore 2, Md.

Calvert County

Coster, Earl S., Solomons, Md.
de Villarreal, Roberto, Prince Frederick, Md.
Jett, Page C., Prince Frederick, Md.
Tobler-Lennhoff, Alice Berg, Calvert County Health Department, Prince Frederick, Md.
Ward, Hugh W., Owings, Md.
Weems, George Jones, Huntingtown, Md.

Caroline County

Anderson, F. M., Federalsburg, Md.
George, D. O., Denton, Md.
Knotts, E. Paul, Denton, Md.
Lennon, W. E., Federalsburg, Md.
Plummer, Harold B., Preston, Md.
Riley, Edwin G., Denton, Md.
Silver, H. Fletcher, Goldsboro, Md.
Stonesifer, Charles H., Greensboro, Md.
White, George S., Ridgely, Md.
Winnacott, Charles H., Ridgely, Md.
*Wright, James F., Denton, Md.
Wright, Robert, Greensboro, Md.

Carroll County

Bare, S. Luther, Westminster, Md.
Benner, Chandos M., Taneytown, Md.
Beyer, M. Virginia, Sykesville, Md.
Billingslea, Charles Levine, Westminster, Md.
Bush, Edgar Murray, Hampstead, Md.
Bush, Joseph E., Hampstead, Md.
Chepko, Julius, Westminster, Md.
Culwell, William, Mt. Airy, Md.
Foard, Wilbur H., Manchester, Md.
Foutz, Charles R., Westminster, Md.
Gardner, Robert E., Springfield State Hospital, Sykesville, Md.
Grabill, J. Stanley, Mt. Airy, Md.
Gross, Gertrude, Sykesville, Md.
Gross, Martin, Springfield State Hospital, Sykesville, Md.
Hentzen, J. W., Sykesville, Md.
Hitchman, Irene, Springfield State Hospital, Sykesville, Md.
Jennette, W. C., Westminster, Md.
Kamm, Ilse, Sykesville, Md.
Lawson, William H., Eldersburg, Md.
McVaugh, R. S., Taneytown, Md.
Margolin, Ellis S., Sykesville, Md.
Marsh, James T., 109 E. Main Street, Westminster, Md.
Mastin, Morrell M., Sykesville, Md.
Mead, Henry C. A., Winder Point, Easton, Md.
Moulton, George Allen, Jr., Westminster, Md.
Porterfield, M. C., Hampstead, Md.
Robertson, Merritt, New Windsor, Md.
Sonnenfeldt, Gertrud, Springfield State Hospital, Sykesville, Md.
Sonnenfeldt, Walther Herbert, Springfield State Hospital, Sykesville, Md.
Speicher, Wilbur Glenn, 135 E. Main Street, Westminster, Md.
Stevens, Walton E., Taneytown, Md.
Stewart, William L., 59 Westmoreland Street, Westminster, Md.
Stitely, Luther C., New Windsor, Md.
Stone, William Carter, Westminster, Md.
Vertal, Thomas, Henryton, Md.
Wilkins, Elizabeth Reese, Westminster, Md.
Woodward, Lewis K., Westminster, Md.

Cecil County

Andrews, S. Ralph, 233 E. Main Street, Elkton, Md.
Bates, J. Herbert, Elkton, Md.
Benson, C. I., Port Deposit, Md.
Brannon, E. P., Asso., Veterans Administration Hospital, Perry Point, Md.
Byers, John M., Cecil County Health Department, Elkton, Md.
Cantwell, H. A., North East, Md.
Crilly, James A., Asso., Veterans Administration Hospital, Perry Point, Md.
Davis, H. Vincent, Chesapeake City, Md.
Dodson, Richard C., Rising Sun, Md.
Ells, Elizabeth S., Asso., Veterans Administration Hospital, Perry Point, Md.
Fischer, John A., Asso., Veterans Administration Hospital, Perry Point, Md.
Garey, James Lyman, Veterans Administration Hospital, 3900 Loch Raven Blvd., Baltimore 18, Md.
Gerbarg, David S., Asso., Veterans Administration Hospital, Perry Point, Md.
Goldgraben, Seymour, Perry Point, Md.
Huebner, Klaus, North East, Md.
Kreis, George J., Jr., U. S. Naval Station, Roosevelt Road, Puerto Rico.

---

* Deceased.

Magraw, James F., Perryville, Md.
McKnight, Vernon H., Elkton, Md.
Morrison, Winfred T., Earlesville, R.D. 1, Md.
Obenshain, Wallace, 2500th Medical Group, Mitchell Air Force Base, N. Y.
Peffer, Peter A., Asso., Veterans Administration Hospital, Perry Point, Md.
Rhode, C. Martin, Perry Point Hospital, Perry Point, Md.
Richards, Granville H., Port Deposit, Md.
Rothfeld, Ben, Asso., Perry Point, Md.
Sadowsky, Wallace H., Perryville, Md.
Sherman, Leo F., Sophia, W. Virginia
Sprecher, Milford H., Elkton, Md.

Charles County

Andrews, James E., Indian Head, Md.
Bicknell, George C., Marbury, Md.
Coburn, Harry R., Bryantown, Md.
Daly, Richard F., La Plata, Md.
Edelen, Edward J., La Plata, Md.
Espach, Walter C., Ellsmere Farm, Bryan's Road, Md.
Griffen, John H., Hughesville, Md.
Harris, Virginia Goddard, La Plata, Md.
Harris, William A., La Plata, Md.
Higdon, Thomas L., Wayside, Md.
Jarboe, J. Parran, La Plata, Md.
Robie, William A., U. S. Naval Academy, Annapolis, Md.
Susan, Franklin, Indian Head, Md.
Weber, George Samuel, Waldorf, Md.
Wooddy, Arthur, La Plata, Md.

Dorchester County

*Brown, Hugh, Cambridge, Md.
Brown, Robert D., Emeritus, East New Market, Md.
Bunker, Albert E., Cambridge, Md.
Frazier, L. G., Emeritus, 719 S. Garnett Street, Henderson, N. C.
Gunby, Walter E., Cambridge, Md.
Hanks, William H., Cambridge, Md.
Harrison, William C., Hurlock, Md.
Johnson, Walter B., Cambridge, Md.
Jones, E. A. P., Emeritus, Cambridge, Md.
Jones, Kenneth B., Church Creek, Md.
Mace, John, Jr., 6 Church Street, Cambridge, Md.
Marynov, Alfred R., Cambridge, Md.
Marynov, Lawrence, 136 Race Street, Cambridge, Md.
Meade, James W., Jr., Fishing Creek, Md.
Meekins, Gilbert E., Cambridge, Md.
Miller, Frederick A., Cambridge, Md.
Parton, George, Cambridge, Md.
Reddick, Robert H., Eastern Shore State Hospital, Cambridge, Md.
Steele, Guy, Emeritus, Cambridge, Md.
Thompson, James Upshur, Cambridge, Md.
West, G. Brooks, Jr., Cambridge, Md.
Winiarz, Elizabeth A., Eastern Shore State Hospital, Cambridge, Md.
Winiarz, W.V., Eastern Shore State Hospital, Cambridge, Md.
Wolff, Eldridge H., Cambridge, Md.

Frederick County

Ash, Howard W., 415 South Boulevard, Evanston, Illinois
Baer, Ridgely W., Frederick, Md.
Baxter, J. Murray, 4 E. Church Street, Frederick, Md.
Beall, Ira W., Libertytown, Md.
Belt, Norvell, Professional Bldg., Frederick, Md.
Birely, Morris Franklin, Thurmont, Md.
Bourne, U. G., Jr., 30 W. All Saints Street, Frederick, Md.
Bourne, U. G., Sr., 30 W. All Saints Street, Frederick, Md.
Brice, Arthur Talbott, Jefferson, Md.
Burgess, Forbes H., Winchester Hall, Frederick, Md.
Cadle, W. R., Emmittsburg, Md.
Chase, Henry V., 7 E. Church Street, Frederick, Md.
Conley, Charles H., Frederick, Md.
Conley, Charles H., Jr., Professional Building, Frederick, Md.
Culler, John McCleary, 17 E. Second Street, Frederick, Md.
Derr, John S., 35 E. Church Street, Frederick, Md.
Dettbarn, Ernest, E. Church Street, Frederick, Md.
Fifer, Jesse S., 35 E. Church Street, Frederick, Md.
Furie, Robert, Frederick Memorial Hospital, Frederick, Md.
Goodman, James Monroe, Emeritus, Frederick, Md.
Gray, James King, Thurmont, Md.
Green, Thomas W., Station Hospital, Camp Detrick, Frederick, Md.
Guest, Russell L., 7 E. Church Street, Frederick, Md.
Harp, Jacob Elmer, Middletown, Md.
Horine, Arlington G., Brunswick, Md.
Kline, Horace F., 7 N. Market Street, Frederick, Md.
Lansdale, P. G., 35 E. Church Street, Frederick, Md.
Lyon, Isadore B., State Sanatorium, Md.
McAdoo, Hosea W., Ijamsville, Md.
Martin, Rex, R. E. Church Street, Frederick, Md.
Messler, John H., Johnsville, Md.
Miller, Edgar A., Jr., Walkersville, Md.
Orrison, William W., Brunswick, Md.
Pearre, A. Austin, 4 E. Church Street, Frederick, Md.
Pilgrim, Robert, Professional Building, Frederick, Md.
Pruitt, Charles E., Brunswick, Md.
Quill, Thomas H., Professional Building, Frederick, Md.
Riggs, George Henry, Francis Scott Key Hotel, Frederick, Md.
Schoolman, Louis Robert, Professional Building, Frederick, Md.
Slusher, H. J., 7 E. Church Street, Frederick, Md.
Smith, J. G. F., Brunswick, Md.
Smith, W. M., Frederick, Md.
Stone, Thomas E., 7 E. Church Street, Frederick, Md.
Stoner, James E., Jr., Walkersville, Md.
Thomas, Bernard O., Professional Building, Frederick, Md.
Thomas, Bernard O., Jr., Professional Building, Frederick, Md.
Thomas, Edward P., 4 E. Church Street, Frederick, Md.
Thomas, James B., Professional Building, Frederick, Md.
Turner, Robert S., Jr., USA, 13912 Laurel Street, Santa Ana, Calif.
White, Byron D., 35 E. Church Street, Frederick, Md.

---

* Deceased.

Woodward, Arthur, 4240 Flowerton Road, Baltimore 29, Md.
Worthington, Frank D., Frederick, Md.

Harford County

Barthel, Robert, Forest Hill, Md.
Cowan, Claude L., 569 Revolution Street, Havre de Grace, Md.
Dodd, J. W., 3 Aberdeen Avenue, Aberdeen, Md.
Dolce, Daniel D., 419 Congress Avenue, Havre de Grace, Md.
Dorogi, Benjamin, Cardiff, Md.
Finney, James McC., 330 S. Union Avenue, Havre de Grace, Md.
Foley, Charles J., 400 S. Union Avenue, Havre de Grace, Md.
Folweiler, Robert A., 226 Union Avenue, Havre de Grace, Md.
Hatem, Frederick J., 17 N. Philadelphia Blvd., Aberdeen, Md.
Hayman, Charles R., Health Department, Bel Air, Md.
Hodous, Frederick O., Edgewood, Md.
Horky, J. Ralph, Churchville, Md.
Hudson, Willard P., Forest Hill, Md.
Lewis, Addison LeRoy, 214 N. Union Avenue, Havre de Grace, Md.
McDonald, Brown, Jr., 100 Parke Street, Aberdeen, Md.
Neff, C. A., Street, Md.
Norment, Richard III, 407 Union Avenue, Havre de Grace, Md.
Palmer, Gerald C., 211 S. Main Street Bel Air, Md.
Phillips, Dudley, Darlington, Md.
Richardson, Charles, Main Street, Bel Air, Md.
Rodman, Peter P., P.O. Box 441, Aberdeen, Md.
Sandecki, Alexander, 15 Courtland Street, Bel Air, Md.
Sidwell, Harvey P., 138 N. Main Street, Bel Air, Md.
Simon, Edward J., 123 S. Union Avenue, Havre de Grace, Md.
Snodgrass, Frank P., Darlington, Md.
Stansbury, George, 569 Revolution Street, Havre de Grace, Md.
Stewart, Charles W., Jr., 1 Cedar Street, Edgewood, Md.
Stonesifer, Paul, 615 Hickory Avenue, Bel Air, Md.
Thomison, Samuel J., Jr., Jarrettsville, Md.
*Van Bibber, Armfield F., Bel Air, Md.
Waschman, Irvin L., Union Avenue & Franklin Street, Havre de Grace, Md.
Wolbert, Frank, Jr., Havre de Grace, Md.

Howard County

Brumbaugh, B. Bruce, Elkridge, Md.
Burgtorf, George E., Jr., Ellicott City, Md.
Fisher, Donald E., 107 S. Belle Grove Road, Catonsville, Md.
Gassaway, William N., Emeritus, Ellicott City, Md.
Groleau, George E., Elkridge, Md.
Hemminger, Earl W., Ellicott City, Md.
Shipley, Frank Earl, Savage, Md.
Shrop, Theodore R., Health Department, Ellicott City, Md.
Taylor, Irving J., Ellicott City, Md.
Whitaker, Charles Stanley, Clarksville, Md.

Kent County

Brice, Merritt, Millington, Md.
Copeland, H. P., Chestertown, Md.
*Dedman, James E., Betterton, Md.
Dick, A. C., Chestertown, Md.
Ensor, Robert Ellwood, 2272 Medical Squadron, Orlando Air Force Base, Orlando, Florida.
Farr, Robert W., Chestertown, Md.
Gulbrandsen, Oskar S., Chestertown, Md.
Hamilton, H. H., Millington, Md.
Joyce, Florence D., Worton, Md.
Kester, Eugene, Rock Hall, Md.
Simpers, Henry G., Chestertown, Md.
Smith, Willard F., Rock Hall, Md.
Whitsitt, A. F., Chestertown, Md.

Montgomery County

Adland, Marvin L., 312 Essex Avenue, Chevy Chase, Md.
Alden, Manning W., 915 Silver Spring Avenue, Silver Spring, Md.
Allen, Samuel, 18 Fawcett Street, Kensington, Md.
Anderson, Clifford R., Washington Sanitarium & Hospital, Takoma Park, Md.
Andren, Henry E., 7600 Carroll Avenue, Takoma Park, Md.
Andrews, John M., 9601 Colesville Road, Silver Spring, Md.
Angle, Robert G., 106 Del Ray Avenue, Bethesda, Md.
Aud, William Dudley, 9006 Colesville Road, Silver Spring, Md.
Avery, John Lawrence, 10110 Georgia Avenue, Silver Spring, Md.
Baernstein, Laura Nelson, 4611 Highland Avenue, Bethesda, Md.
Ball, John G., 7936 Georgetown Road, Bethesda, Md.
Bankhead, J. Marion, 9601 Sutton Place, Silver Spring, Md.
Barrett, B. Irene, 6900 Wisconsin Avenue, Chevy Chase, Md.
Barrett, Robert J., 6900 Wisconsin Avenue, Chevy Chase, Md.
Bauer, Arthur S., 8641 Colesville Road, Silver Spring, Md.
Bauersfeld, Emil G., 7345 Wisconsin Avenue, Bethesda, Md.
Bauersfeld, S. Richard, 7345 Wisconsin Avenue, Bethesda 14, Md.
Bier, Robert A., 9128 Woodland Drive, Silver Spring, Md.
Bird, J. W., Sandy Spring, Md.
Black, Emilie Annabelle, 5081 Bradley Blvd., Bethesda, Md.
Bonifant, Dement, Sandy Spring, Md.
Boyer, George M., Damascus, Md.
Boyer, M. McKendree Damascus, Md.
Brennan, Andrew J., 7725 Aberdeen Road, Bethesda, Md.
Broschart, Frank J., 8 Russell Avenue, Gaithersburg, Md.
Brownsberger, John F., Washington Sanitarium & Hospital, Takoma Park, Md.
Bullard, Dexter M., Chestnut Lodge, Rockville, Md.
Burnham, Donald Love, 500 W. Montgomery Avenue, Rockville, Md.
Calvert, Read N., 7894 Georgia Avenue, Silver Spring, Md.
Cantor, Paul D., 4709 Montgomery Lane, Bethesda, Md.
Chapman, Katherine A., 3924 Baltimore Street, Kensington, Md.
Coale, Robert N., 8707 Cranbrook Court, Bethesda, Md.
Cohen, Maynard I., 2412 Colston Drive, Silver Spring, Md.

---

* Deceased.

Congdon, Charles C., Asso., Ntl. Cancer Inst., Bethesda, 14, Md.
Cotlove, Elaine W., 10302 Warner Avenue, Kensington, Md.
Coyne, Arthur E., Washington Sanitarium & Hospital, Takoma Park, Md.
Cross, Merrill M., 8248 Georgia Avenue, Silver Spring, Md.
Cullander, Cecil C. H., 500 W. Montgomery Ave., Rockville, Md.
Curry, John J., 11301 Georgia Avenue, Silver Spring, Md.
Curtis, Leo M., 5707 Wisconsin Avenue, Chevy Chase, Md.
Cushard, William G., 703 E. Leland Street, Chevy Chase, Md.
Cuvillier, L. Marshall, Jr., 1407 Woodside Parkway, Silver Spring, Md.
Danish, Abraham W., 913 Pershing Drive, Silver Spring, Md.
De Lawter, De Witt, E., 7325 Aberdeen Road, Bethesda 14, Md.
Diamond, Herbert H., 8224 Georgia Avenue, Silver Spring, Md.
Donovan, Leo I., 8016 Old Georgetown Road, Bethesda, Md.
Downing, Virginia, Asso., Temporary 74, The Fenway, Boston 15, Mass.
Dun, Alan A., 6719 Fairfax Road, Bethesda 14, Md.
Dunn, E. A. A., Asso., 4617 East West Highway, Bethesda, Md.
Dyrud, Jarl E., Chestnut Lodge, Rockville, Md.
Eastman, W. W., 8700 Colesville Road, Silver Spring, Md.
Eig, Blaine H., 8641 Colesville Road, Silver Spring, Md.
Eldred, Stanley H., 7710 Granada Drive, Bethesda 14, Md.
Ellicott, Valcoulon L., County Health Department, Rockville, Md.
Fawcett, John, Boyds, Md.
Felix, Robert H., Asso., Ntl. Institute of Mental Health, Bethesda, Md.
Firminger, Harlan I., University of Kansas Medical School, Kansas City 3, Kansas
Fitzgerald, Bernard A., 9620 Old Bladensburg Road, Silver Spring, Md.
Fitzgerald, James Blaine, 4641 Montgomery Avenue, Bethesda 14, Md.
Fromm-Reichman, Frieda, 500 W. Montgomery Avenue, Rockville, Md.
Gadol, William N., 8016 Old Georgetown Road, Bethesda, Md.
Gau, Bertrand C. R., 1001 Seminary Road, Silver Spring, Md.
George, George P., 9404 Colesville Road, Silver Spring, Md.
Geist, Jack E., 918 Ellsworth Drive, Silver Spring, Md.
Gibson, Robert W., 614 Monroe Street, Rockville, Md.
Gill, Dorothy, 7011 Arlington Road, Bethesda, Md.
Glick, Herbert D., 8301 Piney Branch Road, Silver Spring, Md.
Gray, George A., Jr., 104 Chevy Chase Drive, Chevy Chase, Md.
Greenberg, Robert M., 2304 Colston Drive, Silver Spring, Md.
Haak, Paul, 8801 Colesville Road, Silver Spring, Md.
Hall, Edwin P., 1701 Forest Glen Road, Silver Spring, Md.
Hall, W. G., 615 W. Montgomery Avenue, Rockville, Md.
Hare, Robert A., Washington Sanitarium and Hospital, Takoma Park, Md.
Harmon, Ernest E., 12 Cleveland Avenue, Takoma Park, Md.
Hartley, G. V., 103 Forest Avenue, Rockville, Md.
Hindman, Thomas A. N., 6 W. Washington Street, Kensington, Md.
Hornibrook, John W., Ntl. Institute of Health, Bethesda, Md.
Huff, Wheeler O., 4529 Maple Avenue, Bethesda, Md.
Hughes, Emma, Washington Sanitarium and Hospital, Takoma Park, Md.
Jaeger, Henry William 918 Ellsworth Drive, Silver Spring, Md.
Jaeger-Lee, Dorothy S., 913 Pershing Drive, Silver Spring, Md.
Jaggers, Frank Y., Jr., 5707 Wisconsin Avenue, Chevy Chase 15, Md.
Jameson, Patrick C., 11602 Georgia Avenue, Wheaton, Md.
Jarvis, Marjorie, 100 Park Street, Rockville, Md.
Jones, Phillip Edward, 904 Ellsworth Drive, Silver Spring, Md.
Jones, Stephen Noland, RFD. #4, Rockville, Md.
Joyce, William T., 546 Maple Ridge Road, Bethesda, Md.
Kenrick, Joseph P., 7942 Wisconsin Avenue, Bethesda, Md.
Kerr, James P., Damascus, Md.
Kimble, J. Norman, Washington Sanitarium and Hospital, Washington 12, D. C.
Kress, Daniel H., 405 Niblic Avenue, Orlando, Fla.
Kress, Lauretta E., 405 Niblic Avenue, Orlando Fla.
Kroutil, Ludwig C., 904 Ellsworth Drive, Silver Spring, Md.
Kroutil, Persis M., 904 Ellsworth Drive, Silver Spring, Md.
Landman, Manuel P., 216 Dearborn Avenue, Silver Spring, Md.
Lang, Louis R., 8641 Colesville Road, Silver Spring, Md.
Laughlin, Henry P., 6206 Hillcrest Place, Chevy Chase, Md.
Laughlin, Kenneth F., 934 Ellsworth Drive, Washington Building, Silver Spring, Md.
Ligon, Charles H., Sandy Spring, Md.
Linthicum, William A., 110 S. Washington Street, Rockville, Md.
Lombard, Peter N., 812 Sligo Avenue, Silver Spring, Md.
Lorenz, Elmer W., Washington Sanitarium and Hospital, Takoma Park, Md.
Lucius, Naomi T., 9601 Georgia Avenue, Silver Spring, Md.
Lynch, John M., Asso., Ntl. Inst. of Health, Bethesda 14, Md.
McCarrick, James P., 326 E. Montgomery Avenue, Rockville, Md.
McDonald, Audrey J., Montgomery County Health Dept., Rockville, Md.
McNeill, Willard P., 8801 Colesville Road, Silver Spring, Md.
Mahler, Paula T., 8712 Old Georgetown Road, Bethesda, Md.
Marks, Irving L., 6306 Wisconsin Avenue, Chevy Chase, Md.
Martens, Vernon E., Asso., U. S. Naval Medical School, Bethesda, Md.
Martinez, F. A., 7209 Overhill Road, Bethesda 14, Md.
Masur, Jack, Asso., 3821 Gramercy Street, N. W., Washington, D. C.
Maxwell, George A., 918 Ellsworth Drive, Silver Spring, Md.
Meade, DeVoe K., 504 Tulip Avenue, Takoma Park, Md.
Meyers, Wilford D., 8619 Flower Avenue, Takoma Park, Md.
Miller, William C., 7 Brooks Avenue, Gaithersburg, Md.
Mitchell, Claude William, 8055 Thirteenth Street, Silver Spring, Md.

Mitchell, Harold H., R.F.D. #2, Gaithersburg, Md.
Mitchell, Reginald H., 6900 Wisconsin Avenue, Chevy Chase, Md.
Mones, Marvin I., 918 Ellsworth Drive, Silver Spring, Md.
Moody, Louis H., Jr., 918 Ellsworth Drive, Silver Spring, Md.
Mook, Wallace N., 805 Carroll Avenue, Takoma Park, Md.
Morse, H. T., 7030 Carroll Avenue, Takoma Park, Md.
Murgolo, V. John, 913 Pershing Drive, Silver Spring, Md.
Murphy, William S., 615 W. Montgomery Avenue, Rockville, Md.
Nicholson, Ralph L., Eucom. Medical Training Center, APO 108 Army U. S., ℅ P.M., New York
Norcross, John A., 9211 Georgia Avenue, Silver Spring, Md.
Norton, Alfred, 4711 Highland Avenue, Bethesda, Md.
O'Brien, Helen K., 26 W. Montgomery Avenue, Rockville, Md.
Oliver, Norman, 1108 Woodside Parkway, Silver Spring, Md.
O'Neill, Allen J., 7940 Old Georgetown Road, Bethesda 14, Md.
Patrick, George B., Jr., 8700 Colesville Road, Silver Spring, Md.
Patten, Ralph F., 8641 Colesville Road, Silver Spring, Md.
Perry, Morris, 11602 Georgia Avenue, Silver Spring, Md.
Price, Florence R., 4615 Edgefield Road, Parkwood, Bethesda 14, Md.
Price, V. E., 4615 Edgefield Road, Parkwood, Bethesda 14, Md.
Queen, Greenville Burton, 7112 Willow Ave., Takoma Park, Md.
Reap, Belden R., 11502 Grandview Avenue, Silver Spring, Md.
Reith, M. Isabel, 504 Tulip Avenue, Takoma Park, Md.
Richwine, Alfred H., 5522 Western Avenue, Chevy Chase, Md.
Rintz, Norman C., 4701 Bradley Boulevard, Bethesda 14, Md.
Robben, John O., 7930 Georgia Avenue, Silver Spring, Md.
Roberts, James A., 8901 Colesville Road, Silver Spring, Md.
Rogers, John S., 1009 Seminary Road, Silver Spring, Md.
Rohrbaugh, Austin B., Jr., 104 Chevy Chase Drive, Chevy Chase, Md.
Rosenberger, Gordon S., 310 W. Montgomery Avenue, Rockville, Md.
Saxon, Jackson A., 7806 Garland Avenue, Takoma Park, Md.
Schultz, George N., 9514 Colesville Road, Silver Spring, Md.
Schumacher, Jack, 105 Russell Avenue, Gaithersburg, Md.
Segall, Harold, 11301 Georgia Avenue, Wheaton, Md.
Sewell, Webster, Norbeck, R.F.D. 1, Silver Spring, Md.
Sharpe, George, 10644 Connecticut Avenue, Kensington, Md.
Shirley, R. King, 26 Walker Avenue, Gaithersburg, Md.
Shoemaker, Norman C., 8005 Woodbury Drive, Silver Spring, Md.
Smith, Gordon Murdock, Barnesville, Md.
Smith, John E., 5029 Bethesda Ave., Bethesda, Md.
Snow, Lee B., 9013 Flower Avenue, Silver Spring, Md.
Snow, Margaret, 9013 Flower Avenue, Silver Spring, Md.
Spence, George Roland, 904 Ellsworth Drive, Silver Spring, Md.
Standard, Ruth, Washington Sanitarium and Hospital, Takoma Park, Md.
Starr, Paul V., Washington Sanitarium, Takoma Park, Md.
Staveren, Herbert H., 11th & U Streets, N. W., Washington, D. C.
Tamagna, Irene, 6501 Connecticut Avenue, Chevy Chase, Md.
Thibadeau, Andrew F., 10111 Colesville Road, Silver Spring, Md.
Thibadeau, Richard B., Medical Director, Cedar Craft Sanitarium, Silver Spring, Md.
Traum, Aaron H., 8237 Georgia Avenue, Silver Spring, Md.
Varner, Philip Holt, 7202 Connecticut Avenue, Chevy Chase, Md.
Voss, Harriet R., 8107 Roanoke Avenue, Takoma Park, Md.
Wardrop, W. B., 837 Bonifant Street, Silver Spring, Md.
Warfield, Charles I., 8035 13th Street, Silver Spring, Md.
Warthen, Robert O., Asso., 62 Lincoln Avenue, Kensington, Md.
Weber, Harry G., Washington Sanitarium and Hospital, Takoma Park, Md.
Weber, Velda A., Washington Sanitarium and Hospital, Takoma Park, Md.
Weigert, Edith V., 12 Oxford Street, Chevy Chase 15, Md.
Weininger, Benjamin, Olney, Md.
Welsh, William W., 104 S. Washington Street, Rockville, Md.
White, Mary Julian, 500 W. Montgomery Avenue, Rockville, Md.
White, Merton L., 9715 Georgia Avenue, Silver Spring, Md.
White, Roland H., 846 Georgia Avenue, Silver Spring, Md.
Yates, Richard, Box 127, Olney, Md.
Zack, Frank A., 8248 Georgia Avenue, Silver Spring, Md.
Ziegler, Mark V., Asso., Brookeville, Md.

Prince George's County

Ammerman, Harvey, Asso., 2025 Eye Street, Washington, D. C.
Bachrach, Louis B., Asso., 915-19th St., N. W., Washington 6, D. C.
Bauer, Richard D., 5610-39th Avenue, Hyattsville, Md.
Bayly, John H., Asso., 1835 Eye Street, N.W., Washington, D. C.
Berman, Leonard Stanley, Asso., 915-19th Street, N. W., Washington, D. C.
Bloomberg, Max, 30-D Ridge Road, Greenbelt, Md.
Bosworth, Robert J., Asso., 811-8th Street, N. E., Washington 2, D. C.
Boyd, James Irving, 8200 Marlboro Pike, S. E., Washington, D. C.
Brady, Z. M., 6715 Roosevelt Street, Seat Pleasant, Md.
Brainin, William, 6124 Central Street, Capitol Heights, Md.
Bunge, Wm. R., 305 Prince George, Laurel, Md.
Campbell, Kenneth D., 9705 Rhode Island Avenue, College Park, Md.
Chase, Wm. W., Asso., 915-19th Street, N. W., Washington, D. C.
Christensen, Thomas A., 6905 Baltimore Blvd., College Park, Md.
Clayman, David S., 6311 Baltimore Avenue, Riverdale, Md.
Clum, John P., 6110-43rd Avenue, Hyattsville, Md.
Coggins, Jesse C., Laurel, Md.
Comeau, U. D., 3303 Perry Street, Mt. Rainier, Md.
Cox, Oliver C., Asso., 4616 Argyle Terrace, Washington 11, D. C.

D'Angelo, John P., 4223 Silver Hill Road, S. E., Washington 20, D. C.
Davies, Harry, Asso., 1835 Eye Street, N. W., Washington, D. C.
Deitz, Aaron, 4314 Gallatin Street, Hyattsville, Md.
Derzavis, Jack L., 4314 Gallatin Street, Hyattsville, Md.
Diamond, Leopold, Asso., 3311 Chauncey Place, Mt. Rainier, Md.
Eisner, William, 30 B. Ridge Road, Greenbelt, Md.
Englar, Thomas S., Asso., County Service Bldg., Hyattsville, Md.
Etienne, Wolcott L., 7010 Wake Forest Drive, College Park, Md.
Evans, Nelsa Wade, Asso., 4319 Clagett-Pine Way, Hyattsville, Md.
Farwell, Charles, 4500 College Avenue, College Park, Md.
Feffer, James J., Asso., 1711 Rhode Island Avenue, N. W., Washington 6, D. C.
Ferris, Harry E., Professional Building, Hyattsville, Md.
Finucane, Daniel Leo, Asso., Glen Dale Sanitorium, Glen Dale, Md.
Fleischer, Ronald S., Hamilton Manor Apts., 5432 Queens Chapel Road, Hyattsville, Md.
Fogel, Julius, Asso., 1726 M. Street, N. W., Washington, D. C.
Frank, William, 132 S. Adams St., Rockville, Md.
French, Leslie, Asso., 1726 Eye Street, N. W., Washington, D. C.
Gallin, Leon L. No address given
Geiger, Hugh, 3001 Lancer Drive, Hyattsville, Md.
Gibson, Walcutt W., Asso., Box 5109, Branch Avenue, Washington 20, D. C.
Gilbert, Jules, Asso., 3200 Chillen Road, Mt. Rainier, Md.
Glickfield, H., Wayne, 6826 Riggs Road, Hyattsville, Md.
Grassgreen, Irvin, 2503 Queens Chapel Road, Mt. Rainier, Md.
Griffith, W. Allen, 4900 Ricatan Street, College Park, Md.
Hagan, Wm. B., 3306 Rhode Island Avenue, Mt. Rainier, Md.
Hageage, Charles C., 3308 Perry Street, Mt. Rainier, Md.
Hageage, George J., 3717-38th Avenue, Cottage City, Md.
Haught, John S., 3306 Rhode Island Avenue, Mt. Rainier, Md.
Hays, Leonard, 5201 Baltimore Avenue, Hyattsville, Md.
Holbrook, William A., Jr., 4500 College Avenue, College Park, Md.
Hughes, Lloyd W., 4605 Fordham Road, College Park, Md.
Hutchins, Thomas M., 2715 Lake Avenue, Cheverly, Md.
Jimal, Louis M., 4008 Bladensburg Road, Cottage City, Md.
Kauffman, Julius, 5102 Annapolis Road, Bladensburg, Md.
Kehoe, John, 3403 Cheverly Avenue, Cheverly, Md.
Kelley, Gordon W., 6124-41st Avenue, Hyattsville, Md.
Kettler, Martin, Glenn Dale Sanitorium, Glenn Dale, Md.
Kylar, Stephen L., U. S. Army Hosp., Camp Carson, Colo. Springs, Colo.
Lapin, Alfred R., Clinton Medical Center, Clinton, Md.
Latimer, Guy W., 4313 Gallatin Street, Hyattsville, Md.
Lavine, Harold, Asso., 5802 Baltimore Avenue, Hyattsville, Md.
Lavine, Oscar, 3215 Varnum Street, Mt. Rainier, Md.
Lowry, S. W., 601 Washington Blvd., District Heights, Md.
McCeney, Robert S., Laurel, Md.
McDonald, Joseph J., 7309 Riggs Road, W. Hyattsville, Md.
McDonnell, Henry B., 7400 Dartmouth St., College Park, Md.
McLain, George H., Asso., 1746 K Street, N. W., Washington, D. C.
McLendon, Preston A., Asso., 2146 Wyoming Avenue, N. W , Washington, D. C.
Malin, Lawrence White, 102 W. Madison Avenue, Riverdale, Md.
Maloney, John T., 2202 Cheverly Avenue, Cheverly-Hyattsville, Md.
Mendel, C. Louis, 4506 College Street, College Park, Md.
Michel, Helene Doetsch, Asso., 6518-40th Avenue, University Parkway, Hyattsville, Md.
Miller, Benjamin S., 3213 Varnum Street, Mt. Rainier, Md.
Mock, Ernest L., Asso., 4212-29th Street, Mt. Rainier, Md.
Moyers, Waldo B., 3303 Perry Street, Mt. Rainier, Md.
Murphy, James P., Asso., 1911 R Street, N.W., Washington, D. C.
Musser, Frederick, 7409 Varnum Street, Bellmeade, Hyattsville, Md.
Neviaser, Julius, Asso., 1918 K Street, N. W., Washington, D. C.
*Norton, William H., Mt. Rainier, Md.
Perkins, John, 5301 Hamilton Street, E. Riverdale, Md.
Phillips, Rowland S., Glenn Dale Sanatorium, Glenn Dale, Md.
Rabkin, Boris, 1200 Lebanon Street, Silver Spring, Md.
Rector, George M., Aquasco, Md.
Ritchie, W. S., Ritchie Road, S. E., Washington, D. C.
Roth, Albert, 5435 Madison Street, East Riverdale, Md.
Sands, James P., Laurel Sanitorium, Laurel, Md.
Sarao, E. A., 7006 N. H. Avenue, Takoma Park, Md.
Sasscer, James G., Upper Marlboro, Md.
Sasscer, Robert B., Upper Marlboro, Md.
Schwartzbach, Saul, Asso., 1726 Eye Street, N. W., Washington, D. C.
Shear, M. R., 3200 Chillum Road, Mt. Rainier, Md.
Shipley, Trajan E., 3450 Med. Gp. ATRC, Frances E. Warren AFB, Cheyenne, Wyo.
Stecher, William, Jarboe Avenue, Burnt Mills Hills, Silver Spring, Md.
Stewart, N. B., 314 Compton Avenue, Laurel, Md.
Sugar, Samuel J. N., 4300 Kaywood Gardens, Mt. Rainier, Md.
Sugar, S. Jack, 5802 Baltimore Avenue, Hyattsville, Md.
Suraci, Alfred, Asso., 915-19th Street, N. W., Washington 6, D. C.
Tilley, Russell M., 5250 South Ellis Avenue, Chicago 15, Ill.
Ulshafer, Chloe B., 322 Prince George Street, Laurel, Md.
Ulshafer, Thomas R., 322 Prince George St., Laurel, Md.
Van Natta, Paul Clopton, 5440 Silver Hill Road, Parkland, Md.
Warren, B. P., Laurel, Md.

---

* Deceased.

Warren, J. Francis, Asso., 2015 "R" Street, N. W., Washington, D. C.
Warren, John M., 305 Prince George Street, Laurel, Md.
Watkins, Dayton O., 5208 Annapolis Road, Bladensburg, Md.
Weiss, Moe, Glenn Dale Sanitarium, Glenn Dale, Md.
Wilkinson, Rowland Francis, Asso., 4404 Queensbury Road, Riverdale, Md.
Wodak, Hans, 6-5 S. Ridge Road, Greenbelt, Md.
Wolfe, Henry R., 5603 Chillum Heights Drive, Hyattsville, Md.

Queen Anne's County

Callison, Caroline H., Queen Anne's County Health Dept., Centreville, Md.
Dudley, Norman S., Church Hill, Md.
Fisher, W. H., Centreville, Md.
Hoyt, Irvin G., Queenstown, Md.
Layton, C. Rodney, Centreville, Md.
McPherson, H. F., Centreville, Md.
Martin, G. William, Jr., Queenstown, Md.
Miller, Robert B., 307 Talbot Ave., Cambridge, Md.
Sattelmaier, Theodor, Stevensville, Md.
Shepherd, Frederick P., 814 Legare Road, Aiken, S. C.

St. Mary's County

Barbarich, Michael, Laurence Avenue, Leonardtown, Md.
Bean, Philip J., Great Mills, Md.
Boyd, William D., Leonardtown, Md.
Camalier, F. A., Leonardtown, Md.
Fuchs, Robert T., Leonardtown, Md.
Greenwell, Francis Floyd, Leonardtown, Md.
Guyther, J. Roy, Mechanicsville, Md.
Houser, Alan D., Leonardtown, Md.
Johnson, Leonard B., Morganza, Md.
Lane, Julian S., Lexington Park, Md.
Palmer, Robert Vickery, Avenue, Md.
Patrick, William H., 323 Midway Drive, Lexington Park, Md.
Sothoron, L. J., Charlotte Hall, Md.
Thibadeau, Robert T., St. Inigoes, Md.
Thompson, Earl, Piney Point, Md.

Somerset County

Barr, A. N., Crisfield, Md.
Callicott, Robert Malcolm, 20 Prince William Street, Princess Anne, Md.
Chambers, Merritt G., Asso., Pittsville, Md.
Collins, Clarence E., Crisfield, Md.
Coulbourn, George C., Marion Station, Md.
Coulbourn, William H., Crisfield, Md.
Dunn, George M. (Address unknown)
Johnson, Robert H., Princess Anne, Md.
Lewis, Robert F., Crisfield, Md.
Peyton, Sarah M., Crisfield, Md.
Rawley, C. G., Crisfield, Md.
Schwatka, C. Taylor, Columbia Avenue, Crisfield, Md.
Whaley, T. B., Princess Anne, Md.

Talbot County

Ambler, J. Thompson B., Easton, Md.
Baker, J. Tyler, Easton, Md.
Bartley, Donald F., 9 N. Hanson Street, Easton, Md.
Baybutt, J. E., 214 E. Dover Street, Easton, Md.
Buell, Martin F., Easton, Md.
Cecil, A. B., Jr., Easton, Md.
Cox, P. Evans, Easton, Md.
Eareckson, Vincent O., Jr., 300 South Hanson Street, Easton, Md.
Hammond, W. T., Easton, Md.
Harrison, Thurston, Easton, Md.
Kinnamon, Howard F., Easton, Md.
Krech, Shepard, Jr., 9 N. Hanson Street, Easton, Md.
Lawson, Edward Kirby, Oxford, Md.
Lederer, Kurt, Queen Anne, Md.
Mason, Frank E., 18 W. Dover Street, Easton, Md.
Milholland, Arthur Vincent, St. Michaels, Md.
Noble, William D., 214 E. Dover Street, Easton, Md.
Palmer, Margaret Virginia, Easton, Md.
Palmer, W. N., Easton, Md.
Perkins, R. L., Royal Oak, Md.
Reeser, Guy M., Tilghman's Island, Md.
Reeser, Guy M., Jr., St. Michaels, Md.
Schmidt, Edward C. H., Easton Hospital, Easton, Md.
Schneider, John F., Easton, Md.
Seymour, W. S., Trappe, Md.
Stevens, A. McC., Easton, Md.
Welty, Louis S., Easton, Md.
Willson, S. Denny, St. Michaels, Md.
Winters, William L., Easton, Md.

Washington County

Bacon, A. Maynard, Jr., 318 N. Potomac Street, Hagerstown, Md.
Baptisti, Arthur, Jr., 115 King Street, Hagerstown, Md.
Beachley, Jack H., 221 W. Washington Street, Hagerstown, Md.
Bell, R. A., 119 N. Potomac Street, Hagerstown, Md.
Bender, W. R., 1140 Potomac Avenue, Hagerstown, Md.
Binford, Richard T., 797 St. Charles Avenue, N. E., Atlanta, Georgia
Binkley, O. H., Hagerstown, Md.
Blair, Harry Edwin, Hagerstown, Md.
Bowman, Harry Daniel, 318 N. Potomac Street, Hagerstown, Md.
Brewer, David R., Clear Spring, Md.
Brumback, Lynn H., 170 W. Washington Street, Hagerstown, Md.
Butterfield, Paul Wm., Long Meadows Apts., 5C, Hagerstown, Md.
Campbell, Edgar Thrall, 145 W. Washington Street, Hagerstown, Md.
Campbell, Robert van Lieu, 145 W. Washington Street, Hagerstown, Md.
Campbell, William D., Hagerstown, Md.
Cohen, Archie Robert, Clear Spring, Md.
Conrad, Robert P., 137 W. Washington Street, Hagerstown, Md.
Crawford, J. W., P.O. Box 654, Martinsburg 1, W. Va.
Ditto, E. W., Jr., Hagerstown, Md.
Dobbie, John James, 115 King Street, Hagerstown, Md.
Dove, Frederick Denton, Jr., 214 N. Potomac Street, Hagerstown, Md.
Dwyer, James Richard, 245 N. Potomac Street, Hagerstown, Md.
Gilmer, H. D., Hagerstown, Md.
Graff, Frederick L., 116 W. Washington Street, Hagerstown, Md.
Graff, Henry F., 116 W. Washington Street, Hagerstown, Md.
Hauver, Richard V., 138 W. Washington Street, Hagerstown, Md.
Hirshman, P. J., 159 W. Washington Street, Hagerstown, Md.
Hoachlander, Eldon George, 115 W. Washington Street, Hagerstown, Md.
Hoffman, Lloyd Augustus, 214 N. Potomac Street, Hagerstown, Md.

Hornbaker, John H., 158 W. Washington Street, Hagerstown, Md.
Houghton, Ira Luther, 115 W. Washington Street, Hagerstown, Md.
Jennings, George., 136 W. Washington Street, Hagerstown, Md.
Keadle, R. F., 132 W. Washington Street, Hagerstown, Md.
Kneisley, Bender B., 148 W. Washington Street, Hagerstown, Md.
Kohler, G. A., Smithsburg, Md.
Layman, J. W., 100 Professional Arts Bldg., Hagerstown, Md.
Layman, Wm. T., 100 Professional Arts Bldg., Hagerstown, Md.
Le Van, G. Wilburforce, Boonsboro, Md.
Link, Vaughen Harwood, 245 N. Potomac Street, Hagerstown, Md.
Lusby, Frank F., 230 N. Potomac Street, Hagerstown, Md.
Macht, Stanley Howard, Washington County Hospital, Hagerstown, Md.
Miller, Victor D., Hagerstown, Md.
Moran, John A., 215 W. Washington Street, Hagerstown, Md.
Mowrer, C. L., Hagerstown, Md.
Norment, Richard B. J., 119 E. Antietam Street, Hagerstown, Md.
Novenstein, Sidney, Funkstown, Md.
Poole, Ernest F., 138 W. Washington Street, Hagerstown, Md.
Prather, Perry F., 5203 Falls Road, Baltimore 10, Md.
Sacchet, Hugo Anthony, 151 W. Washington Street, Hagerstown, Md.
Sachs, James Wilbur, 151 W. Washington Street, Hagerstown, Md.
Schulze, Wm. C., Hagerstown, Md.
Shaffer, Lester M., Hancock, Md.
Shealy, Walter H., Sharpsburg, Md.
Shupp, F. F., 109½ N. Potomac Street, Hagerstown, Md.
Smith, W. Hamilton, 138 W. Washington Street, Hagerstown, Md.
Smoot, Merrill C., 703 Oak Hill Avenue, Hagerstown, Md.
Spence, James E. H., Western Maryland Railway Co., Hagerstown, Md.
Sprecher, Omar Daniel, Jr., 314 N. Potomac Street, Hagerstown, Md.
Stauffer, R. S., Hagerstown, Md.
Sullivan, Margaret E., 318 N. Potomac Street, Hagerstown, Md.
Tabler, Homer E., Hancock, Md.
Tobias, Herbert R., Hancock, Md.
Wade, John H., Boonsboro, Md.
Warden, Jacob Garvin, 832 Potomac Avenue, Hagerstown, Md.
Warner, Mary Patricia, 1306 N. Potomac Avenue, Hagerstown, Md.
Wells, Samuel Robert, Hagerstown, Md.
Welty, Dalton M., E. Hillcrest at Potomac Street, Hagerstown, Md.
Wilson, John Dean, 135 N. Potomac Street, Hagerstown, Md.
Wolfinger, W. L., Waynesboro, Penna.
Wroth, Peregrine, Jr., 145 S. Prospect Street, Hagerstown, Md.
*Yeager, W. H., Hagerstown, Md.
Young, Ralph Funk, 101 E. Potomac Street, Williamsport, Md.
Young, Richard Atlee, 318 N. Potomac Street, Hagerstown, Md.
Young, S. Earl, 148 N. Potomac Street, Hagerstown, Md.
*Zimmerman, I. M., Williamsport, Md.

Wicomico County

Baker, Robert L., 204 N. Division Street, Salisbury, Md.
Barnes, Harry A., Sykesville, Md.
Bishop, James R., E. Main Street, Salisbury, Md.
Bloxom, John M., 304 N. Division Street, Salisbury, Md.
Briele, Henry, 226 N. Division Street, Salisbury, Md.
Christensen, Osborne D., 321 S. Division Street, Salisbury, Md.
Cooper, William, 224 N. Division Street, Salisbury, Md.
Dumeyer, William, Peninsula General Hospital, Salisbury, Md.
Ellis, Wilbur R., Jr., 707 Camden Avenue, Salisbury, Md.
Emrich, William, Hebron, Md.
Fisher, Chas. T., 200 N. Division Street, Salisbury, Md.
Fisher, Wm. Henry, Jr., 226 N. Division Street, Salisbury 1, Md.
Gillis, Marion Howard, Jr., 206 Walnut Street, Salisbury, Md.
Gilmore, David J., 707 Camden Avenue, Salisbury, Md.
Gore, Robert J., Deers Head Hospital, Salisbury, Md.
Gramse, Fred R., 402 S. Division St., Salisbury, Md.
Gray, Wm. David, 334 Camden Avenue, Salisbury, Md.
Hanson, I. Rivers, 204 N. Division Street, Salisbury, Md.
Hearn, Carrie I., 113 W. Church Street, Salisbury, Md.
Howard, Wm. Lawrence, 222 N. Division Street, Salisbury, Md.
Hurdle, Seth H., Wicomico County Health Dept., Watson Memorial Building, Salisbury, Md.
Insley, Philip A., E. Main Street, Salisbury, Md.
Kuhlman, Harry S., Sharptown, Md.
Lambdin, Morris A., 707 Camden Avenue, Salisbury, Md.
Lawrence, Margaret W., R.F.D. #1, Salisbury, Md.
Lawry, Lee L., Jr., Fruitland, Md.
Lewis, Frank R., Willards, Md.
Long, Wm. B., 226 N. Division Street, Salisbury, Md.
McCallum, James A., Deer's Head Hospital, Salisbury, Md.
McCullough, Kendrick, Peninsula General Hospital, Salisbury, Md.
Mann, Hunter R., Professional Bldg., Salisbury, Md.
Mann, Hunter R., Jr., Professional Bldg., Salisbury, Md.
Mattax, Alberta Malcarney, 407 Camden Avenue, Salisbury, Md.
Mattax, Harry McCoy, 407 Camden Avenue, Salisbury, Md.
Mitchell, Andrew C., 228 N. Division Street, Salisbury, Md.
Morgan, W. C., Professional Bldg., Salisbury, Md.
Newman, A. Carleton, 704 Camden Avenue, Salisbury, Md.
Nock, R. M., Professional Bldg. Salisbury, Md.
Poole, Frank, 704 Camden Avenue, Salisbury, Md.
Rademaker, Lee Albert, 224 N. Division Street, Salisbury, Md.
Saunders, Richard H., Nanticoke, Md.
Sembly, G. Herbert, 400 E. Church Street, Salisbury, Md.
Smith, W. Stedman, 224 N. Division Street, Salisbury, Md.
Smith, William, 222 N. Division Street, Salisbury, Md.
Sohler, L. V., 303 East Street, Delmar, Md.
Tamasi, Joseph J., Peninsula General Hospital, Salisbury, Md.

---

* Deceased.

Wanner, Jesse R., Jr., 506 N. Division Street, Salisbury, Md.
Williams, Jack K., Peninsula General Hospital, Salisbury, Md.
Waters, Zack J., 410 S. Division St., Salisbury, Md.

Worchester County

Cohen, Paul, Snow Hill, Md.
Dickerson, John D., Stockton, Md.
LaMar, Robert C., Snow Hill, Md.
Llewelyn, Helen Ensor, 603 Market Street, Pocomoke City, Md.
Llewelyn, Louis Grandeir, 6th Street, Pocomoke City, Md.
O'Donnell, T. F., Berlin, Md.
Robbins, Herman A., 5 Bay Street, Berlin, Md.
Sartorius, Norman E., Pocomoke City, Md.
Sartorius, Norman E., Jr., Pocomoke City, Md.
Schott, Clifford E., 310 N. Main Street, Berlin, Md.
Thomas, Nathaniel R., 703 Baltimore Avenue, Ocean City, Md.
Townsend, Francis J., Jr., Somerset Street, Ocean City, Md.
Trader, Charles W., 302 Market Street, Pocomoke City, Md.
Waesche, F. Seton, Asso., Snow Hill, Md.

Non-Resident Members

Allison, Wilfred J., 2514 Welborn Dallas, Tex.
Archibald, Reginald M., Hospital of the Rockefeller Inst. for Medical Research, 66th Street and York Avenue, New York 21, N. Y.
Austrian, Robert, Kings County Hospital, Brooklyn 3, N. Y.
Bacon, Robert B., "The Oaks," Box 210, Hudson, Fla.
Bardfeld, Benjamin, 1080 E. Landis Avenue, Vineland, N. J.
Barrow, Bernard, Blackstone, Va.
Bowditch, Sarah H., Office of the Surgeon General, Washington 25, D. C.
Brimmer, Karl W., 4001 N. Fifth Street, Arlington, Va.
Bronos, George J., 310 Maple Street, Holyoke, Mass.
Bryan, Elizabeth Lynn, 146 Columbia Heights, Brooklyn 2, N. Y.
Byerly, William L., Jr., 905 Carolina Avenue, Hartsville, S. C.
Colsky, Jacob, Maimanides Hospital, 4802 10th Avenue, Brooklyn, N. Y.
Cook, Sarah, 2609 Lee Blvd., Apt. 202, Arlington 4, Va.
Copeland, Murray M., Westchester Apts. 221-B, 400 Cathedral Avenue, N.W. Washington 16, D. C.
* Corbett, William W., Council on Medical Education and Hospitals, American Medical Association, 535 N. Dearborn Street, Chicago 10, Ill.
Council, Wilfred A. H., Jr., 4 University Court, Charlottesville, Va.
Duvall, Robert Caywood, Jr., 636 Rhode Island Avenue, Norfolk 8, Va.
*Furness, Josephine W., 35–37 Mataman Street, Palmerton, North, New Zealand.
Geiling, E. M. K., University of Chicago, Chicago, Ill.
Gerwig, Walter H., Jr., 1805 Kenyon Street, NW, Washington, D. C.
Graham, Robert Lee, Topeka State Hospital, Topeka Kan.
Grant, H. C., V. A. Regional Office, 2320 La Branch Street, Houston, Tex.
Greif, Roger Louis, Hospital for the Rockefeller Institute for Medical Research, 66th St. and York Avenue, New York 21, N. Y.
Hazard, Elmer C., 75 Washington Street, Long Branch, N. J.
* Holmes, James B., Route 4, Bedford County, Lynchburg, Va.
Hope, Daniel, Jr., Rockwell & Westchester Aves., Catonsville 28, Md.
Keeney, Edmund L., 239 Laurel Street at 3rd Avenue, San Diego 1, Cal.
Ketzky, Joseph William, 4544 Alton Road, Miami Beach 40, Fla.
Lamkin, Edward E., Blackstone Apartments, Baltimore 18, Md.
Lerman, Philip H., 1 Hearth Lane, Westbury, N. Y.
Lipin, Raymond J., V. A. Hospital, 300 E. Roosevelt Road, Little Rock, Ark.
Lyford, John, III, Henry Ford Hospital, Detroit 2, Mich.
Miller, Robert T., Mountain Lake, Lake Wales, Fla.
Mitchell, Henry S., V. A. Center, Martinsburg, W. Va.
Mitchell, William A., 110 S. Raquet Street, Lofkin, Tex.
Molofsky, Leonard Carl, Kaiser Foundation Hospital, Broadway and McArthur Blvd., Oakland 11, Cal.
Peter, Philip A., 1916 Logan Avenue, Cheyenne, Wyo.
Ravitch, Mark M., Mt. Sinai Hospital, New York, N. Y.
Ritchings, Edward Peyton, Victor Cullen Hospital, State Sanitorium, Md.
Schenthal, Joseph E., 1328 Aline Street, New Orleans 15, La.
Shelley, Harry, 3725 Estes Avenue, Nashville, Tenn.
Steinberg, Stanley H., 4214–16th Street, N.W., Washington, D. C.
Thompson, Charles Baker, Lifwyn Foundation, Westport, Conn.
Virgilio, Frank D., USNAS Medical Dept., Patuxent River, Md.
Warren, Thomas N., U. S. Quarantine Station, Rosebank, Staten Island 5, N. Y.

---

* Deceased.

DIRECTORY—TRANSACTIONS

The preceding pages 261–291, which list the membership of the Medical and Chirurgical Faculty from March 31, 1952 through March 31, 1953, are a part of the Transactions for 1953.

Maryland
STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 2 *June, 1953* NUMBER 6

FACULTY FACTS

WALTER N. KIRKMAN*

The Medical and Chirurgical Faculty is composed of 2470 members, representing Baltimore City and every County in the State.

The Faculty, or State Society, is composed of 23 component societies. The ruling and policy-forming body is the House of Delegates, composed of representatives from the component societies. The House of Delegates meets twice a year regularly, and can meet on call—for special purposes. In the interim between meetings of the House of Delegates, the Council, composed of elected members, conducts the affairs of the organization within the policies laid down by the House of Delegates. For the transaction of routine business, an Executive Committee of the Council acts. This Committee consists of the Chairman of the Council and the President, Secretary and Treasurer of the Faculty. The actions of the Executive Committee are reported to, and must be approved by, the Council. The lines of authority are thus clearly drawn, and provision is made to meet any emergency situation, which arrangement is necessary in an organization of this kind. The Staff is well organized and operates in adequate quarters. However, due to the distribution of the membership over a large geographical area, the autonomy of the component societies, and the somewhat infrequent contacts between the State and local societies, the Association as a whole is somewhat loosely organized. In an attempt to bridge this gap, of which the Council is well aware, a member of the Staff has been instructed to visit the component societies at their invitation to discuss the problems of the Faculty, to receive suggestions and constructive criticisms of the work of the Faculty, and in general to attempt to develop stronger cohesion among the component units of the State Society. An organization is only as strong as its most indifferent member, and only as effective as the local units are effective.

It is necessary as never before, perhaps, for the members of the medical profession to organize to protect their freedom of action and their professional standards. It is appropriate to review very briefly some of the activities of the Faculty in accomplishing the objectives of the organization. It is also desirable that the individual members review the benefits which they receive from their membership. In the first place, there is the stimulation which comes from association with those with whom we have mutual interests, problems, and goals. The development of the feeling of "belonging" which has definite psychological value. Then there is the help and assistance which the Faculty, through its various Committees and other agencies, and through the activities of the members, renders the profession.

---

* Director, Medical and Chirurgical Faculty.

There is, for example, the matter of Physicians' Defense. It is unfortunate that reputable physicians, using their best skills and judgement, are still subject to unfair and unwarranted charges of malpractice. Many such charges are made, few are sustained. The Faculty furnishes the services of a highly qualified lawyer, and few such cases ever get into Court, saving the physician time, money and embarrassment. This service may well save the member the amount of his annual dues many times over.

Again, the interests and welfare of the profession are constantly being represented before National, State, and local legislative bodies. At the 90 day sessions of our State Legislature, the Committee on Legislation studies all Bills introduced, and notifies the Officers of any proposed legislation which would affect medical practice. The Committee arranges for hearings before the Legislative Committees to which Bills have been referred, and discusses with individual members of the Legislature the effect of such Bills on the practice of medicine and the people of the State.

Your Officers and Committees also represent the profession in respect to any proposed legislation before the Baltimore City Council affecting the practice of medicine. In these matters, the Officers, the Committees, and the Staff, are constantly on the alert to protect your professional interests.

Finally, your Officers, the appropriate Committees, and the Staff, make every effort to arrange the Annual and Semiannual Meetings so that they will be informative, profitable, and pleasant.

It might be well at this point to list the Committees of the Faculty, so that the importance of their work and the wide coverage of interest can be emphasized. These Committees are:

Executive Committee of the Council
House Committee
Finance Committee
Professional Conduct Committee
Resolutions Committee
Committee on Industrial Health
Legislative Committee
Maternal and Child Welfare Committee
Committee on Medical Research
Joint Committee with the Bar Association on Medicolegal Problems
Memoir Committee
Committee to Study an Insurance Problem
Committee to Cooperate with American Medical Education Foundation
Committee on National Emergency Medical Service
New Building Committee
Committee for the Study of Pelvic Cancer
Physiotherapy Committee
Postgraduate Educational Committee
Committee on Public Instruction
Committee for Better Distribution of Doctors Throughout the State
Committee to Study Legislative and Professional Standards and Staff Relations of Hospitals
Committee for the Study of Certain Phases of Medical Economics

A recent addition to the services of the Faculty is the publication of the monthly Medical Journal, which not only brings to the membership important scientific information, but in addition has been developed as a means of communication between the component societies and from the central organization to the local units. The circulation of the Journal is growing, and the content and format have elicited favorable comment from the membership and subscribers.

Now, let us take an inventory of the physical assets of the Faculty.

The building at 1211–13 Cathedral Street, Baltimore, built in 1909, is well constructed and within the limitation of size, is well adapted to the uses of the organization. The Faculty Building has been appraised for insurance purposes for $220,000, on which we carry insurance to the amount of $175,000, or approximately 80%.

The cost of this property is carried on our books at $110,635.00. In addition, we own the two adjoining houses at 1215 and 1217 Cathedral Street, used by the Board of Medical Examiners, and the Board of Nurses Examiners and the State Nurses Association, respectively. These two houses have been appraised for $23,000 for insurance purposes. The cost of these properties is carried on our books at $19,118.00. Therefore, the total real estate holdings as measured by an appraisal for insurance purposes is as follows:

1211–1213 Cathedral Street (Osler Hall)	$220,000	
1215–1217 Cathedral Street	23,000	$243,000.00
The cost of these properties as carried on our books is:		
1211–1213 Cathedral Street (Osler Hall)	$110,635	
1215–1217 Cathedral Street	19,118	129,753.00
Increase in value		$113,247.00

The Faculty Building houses one of the finest Medical Libraries in the Country. The Library contains more than 50,000 books and 22,000 journals. The members are urged to make use of this storehouse of information and knowledge. The librarians are competent to do your reference work, and, if you cannot personally visit the Library, the books will be sent promptly. Our Library is no further away than your local postoffice. The value of the contents of the Library, using a formula for classification of books and unit values recommended by the American Library Association, and concurred in by our insurance advisors, is placed at $231,370.00. Included are incunabula valued at $30,000.00. The incunabula, of course, came to us by gift.

The other equipment of the building is valued at $18,821.00. This includes office furniture and fixtures, and certain valuable museum pieces such as the medicine chest of Napoleon I. We also have the medicine chest of Dr. Upton Scott, the first President of the Faculty in 1799, and an assortment of early instruments and appliances used in medical and surgical practice. Several hours can be spent in a most interesting manner with these prototypes of modern devices.

In addition, we own by gift, 84 portraits of past Presidents of the Faculty. Two of these portraits are by Rembrandt Peale, and two by Charles Wilson Peale. A qualified artist, familiar with market values, has appraised these 84 portraits for $14,000.00.

The money value of the property of the Faculty is summarized as follows:

Real Estate	$243,000
Library	231,370
Building contents and equipment	18,821
Portraits	14,000
Total	$507,191

A complete inventory has been taken and properly recorded on the books, and the amount of the actual market value of the Faculty's property may be a surprise to some of the members.

In addition, the Faculty has received by gift or inheritance, a total of $137,776.00 in trust funds, the income to be used for specific purposes in some instances, and in others for the general purposes of the organization. Our attorney has studied the wills by which these funds came into the possession of the Faculty, and the attorney has interpreted the intent of the donor in each case. We are very careful to expend these funds only in the manner intended by the donors.

The assets of the Faculty are, therefore, $507,191.00 in buildings and contents, and $137,776.00 in trust funds, or a total of $644,967.00. Against this sum there is a liability of $6,000.00 on a bank loan to purchase the properties at 1215 and 1217 Cathedral Street. These facts are set forth in the Balance Sheet as of December 31, 1952. The books and accounts are audited by a firm of certified public accountants. A complete inventory of all property has been made, adequate insurance is carried, and a budget has been established with proper expenditure controls; a trial balance is taken off the ledger every month, and a purchasing system is in operation. In these respects the administrative affairs of the Faculty follow accepted business practice.

The financial picture outlined above is favorable from the standpoint of two things, namely, fixed assets and trust funds; and yet, by their very nature, they create liabilities and responsibilities of work and administration in properly maintaining the real and personal property of the Faculty, and in implementing the wishes of the donors of our trust funds. Osler Hall is now 44 years old, and while exceptionally well constructed, natural wear and tear and deterioration over this period of time must be offset by remedial measures. The building has been well maintained with respect to ordinary repairs, but a reserve should be established for extraordinary repairs and replacements which are bound to come. Good business administration requires that this be done.

With respect to the contents of the building, including furniture, fixtures, portraits and valuable books, funds must be provided to properly maintain and care for these articles, some of which have come to us by gift or inheritance; to the donors we have a definite responsibility. Our current income does not permit us to properly care for this valuable property. The alternative is deterioration and loss.

The salaries paid our employees are lower than the level paid in the Baltimore area, with the result that it is difficult to retain the services of competent staff people and to fill existing vacancies. This situation has resulted in an unreasonable amount of overtime work on the part of our employees. This condition cannot and should not continue.

Our Library needs the assistance of one additional person to install a modern cataloging system.

Our Medical Journal needs an editorial assistant, and adequate quarters for the performance of the work in connection with preparation of the material for publication.

Our Committees should have some funds for secretarial service and other expenses in connection with their work, so that the Chairmen and members will not have to expend their personal funds, as is the case in some instances now.

The only source of income the Faculty has is from members' dues, income from trust funds, and a small amount from rental for use of our facilities by allied organizations. From all these sources, our total income is $79,488.00 per year, and the same amount is budgeted. That sum is not sufficient to meet the needs above indicated. In our operations we have suffered as other organizations and individuals have from the lowered purchasing power of the dollar, and our income must be increased if we are to meet the present and future needs of the Faculty.

In conclusion, it should be stated that the Faculty has an impressive record of accomplishments for the profession of medicine in this State, and the entire Country. Great names in medicine appear in the records and archives of the Faculty. Great men of medicine have trod the platform and the floor of Osler Hall. Men who have taken time from extraordinarily busy lives, for the work of the Faculty, for the protection of the professional interests of the members, to make their contribution to the advancement of medical science, and for the protection of the health of the people of the State.

The future of the organization as judged by the past is bright, and all members are urged to make use of the facilities available at 1211 Cathedral Street, and to participate in the varied activities of the Faculty.

The National Commission on Chronic Illness was founded in 1949 by the American Hospital Association, the American Medical Association, the American Public Health Association and the American Public Welfare Association.

THE BALTIMORE STUDY OF CHRONIC ILLNESS[1]

DEAN W. ROBERTS, M.D.[2]

Maryland was one of the first states to give serious consideration to the rapidly growing problem of chronic illness. In 1940, the Almshouse Commission, under the chairmanship of Mr. Walter N. Kirkman, recommended that chronic disease hospitals be constructed by the State. Even after 12 years, the report of the Almshouse Commission is remarkably modern in its conception of the problem of chronic illness which faces us today. The recommendation foresaw that chronic disease hospitals would not only replace the outmoded almshouses, but would relieve general hospitals of some of the burden of care of longer term patients.

Recommendations of the Almshouse Commission resulted in the construction of the modern Deer's Head Hospital in Salisbury and the purchase of Sydenham Hospital in Baltimore for development of a chronic disease facility for central Maryland. Funds have also been appropriated for a third chronic disease hospital in Hagerstown.

These hospitals, operated by the State Department of Health, constitute a necessary first step in dealing with the problem of chronic illness. It is apparent, however, that the number of persons with chronic illness is too large and is increasing too rapidly to be dealt with successfully by the sole device of building more and more hospital beds. To study the problem in its broader aspects, the Committee on Medical Care of the State Planning Commission in 1951 established a sub-committee on Chronic Illness under the chairmanship of Dr. Lowell Reed. Dr. Alan Chesney recently succeeded Dr. Reed as chairman of this committee which includes in its membership: Donaldson Brown, Ruth Freeman, R.N., Harry Greenstein, J. L. Lilienthal, M.D., Henry T. Marriott, M.D., A. Austin Pearre, M.D., Clifton Perkins, M.D., Winthrop M. Phelps, M.D., Howard K. Rathbun, M.D., Dean Roberts, M.D., F. F. Schwentker, M.D., Raymond K. Thompson, M.D., Alan Voshell, M. D., Judge T. J. S. Waxter and J. Theodore Wolfe.

One of the difficulties facing this committee was the dearth of factual, quantitative information about chronic illness in Maryland. Limited studies had been made many years before in Hagerstown and the Eastern Health District of Baltimore, but the most comprehensive data available was that derived from the National Health Survey in 1935 and 1936. These data had the defects of being out of date and based exclusively on information obtained from household interviews by lay enumerators. The extent of disability resulting from the illnesses reported was not known. The committee needed accurate information relative to such questions as these: How many people are bed ridden with chronic illness? What proportion of these could be rehabilitated to the point of self-care? How many of them need institutional care? What kind of institutional services are needed and in what quantities? How many need visiting nurses or housekeeping service in order to remain in their own homes? What preventive services would be practical and useful?

---

[1] The following is quoted from the Council minutes of April 27, 1953: "Council unanimously approved the study in principle, and further suggested that in order to render additional assistance, appropriate information be published in the Maryland State Medical Journal."

[2] Director, Commission on Chronic Illness.

Studies designed to answer such questions are costly and time consuming. The sub-committee learned that the national Commission on Chronic Illness, then located in the American Medical Association offices in Chicago, was planning to make such a study in a typical large American city.

Negotiations with the Commission were initiated by the Sub-Committee on Chronic Illness and in April, 1952, an announcement was made that the Commission on Chronic Illness had selected Baltimore as the site for its major Study of Chronic Illness in an Urban Area. The Commission is co-sponsoring a similar study of a rural area in Hunterdon County, New Jersey.

The Commission moved its offices to Baltimore in July, 1952 and is now located in the Johns Hopkins University School of Hygiene and Public Health. An advisory committee for the study has been established with Professor William G. Cochran as chairman and including representatives of the Johns Hopkins University, the University of Maryland School of Medicine, the City and State Health Departments, the Baltimore City Medical Society, and the Medical and Chirurigical Faculty.

The United States Census Bureau has entered into a contract to carry out the first step of the study which is to interview a random sample of households in Baltimore City. The interviewers will interview a responsible adult in approximately 1 out of every 70 households. A series of specific questions will be asked which are designed to elicit information about chronic illness in the family during the preceding year. The questions are quite detailed and it is estimated that interviews will require an average of about one hour. Permission to obtain additional medical information from private physicians and from hospitals will be requested of the interviewees.

From the group interviewed, a sub-sample of about 1,000 persons who have reported chronic illness will be selected for further evaluation by a team consisting of a physician, nurse, social worker and rehabilitation counsellor. Prior medical records will be consulted and such further medical examinations made as are necessary for evaluation of the chronic illness or disability.

The evaluation team will endeavor to do the following: Establish the nature and extent of the condition; estimate the amount and type of care needed; estimate the "rehabilitation potential"; and, insofar as practicable, pursue the question "What preventive medical services could have been applied profitably to this patient during the course of his illness which could have averted, halted or delayed the progress of the disease?"

Those persons who are found by the evaluation team to be capable of rehabilitation to remunerative employment and who are in financial need will be referred to the rehabilitation program of the State Department of Education for an attempt at rehabilitation. This will provide a practical test of methods used in estimating "rehabilitation potential."

The evaluation step, just described, has never been done before and represents by far the most difficult part of the Baltimore study. A special advisory committee under the chairmanship of Dr. Howard Rusk of New York is assisting the Commission in developing uniform procedures for use in the Baltimore study and in its rural counterpart in Hunterdon County, New Jersey.

A final step in the study is designed to test the usefulness and costs of screening tests. A sub-sample of the group interviewed will be offered a series of laboratory screening tests in order to determine the number and type of conditions detected by this procedure which the individual did not mention to the interviewer, or of which he was unaware. This step will provide a means of measuring the "non-manifest" chronic illness. A small sample of those who were negative on screening will be given a careful medical work-up with history, physical and indicated laboratory examinations in order to determine the conditions that will be detected by this procedure which the screening missed. These devices should permit a critical evaluation of the usefulness and limitations of screening tests.

The Baltimore Survey of Chronic Illness is expected to require approximately two years to complete. The interviewing alone, which is to reach an estimated 13,000 people in the sample of 4,000 households, will require a year. To the nation as a whole, the study will provide data which may be useful as a guide to examining needs for facilities in other urban areas. Such basic information is now unavailable anywhere in this country.

To Maryland specifically, the survey will bring much needed data which the sub-committee on Chronic Illness can use in its consideration of the growing problem of chronic illness in this state.

COMMITTEE TO COOPERATE (WITH) AMERICAN MEDICAL EDUCATION FOUNDATION

NEWLAND E. DAY, M.D.*

To the sound of good wishes sent to the American Medical Education Foundation by President Eisenhower the meeting of the Foundation and its national representatives (state chairmen, etc.) opened in Chicago, January 25, 1953. This meeting was a review of the efforts of the various states for the year 1952, closing December 31. Prior to January 25, 1952, Maryland had eighty-seven contributors with a total contribution of $5,713.00. These figures do not include contributions made directly to the medical schools, some of which may be a result of the efforts of the Foundation program. Nevertheless, only monies that actually passed through the Foundation's hands were credited to the Foundation. It was again emphasized in this meeting that the National Foundation's (lay organizations) contingent funds, that is those funds which will be used to match contributions of doctors to the American Medical Education Foundation, can only be used to match monies that come *through* the Foundation. It is hoped, therefore, that regardless of how the contributions were made to the medical school that ultimately a check for the total contributions received by the Alumni Association of Medical Schools will be sent annually to the American Medical Education Foundation and naturally to be earmarked back to that school that sends the check. This would in no way interfere with the administration by the school of the direct contributions. The total fund of the American Medical Education Foundation to be matched by contingent funds hence would be swelled.

The chairman wishes to thank the editor and secretarial staff of the State Journal for their splendid cooperation in connection with publicity for the program, and also the faculty office staff for their accurate recording of the tally and prompt acknowledgements of all contributions. Hearty thanks go to our committee, who have served well this past year. To the new members of the committee, whose names are listed herein, I bid you welcome and am looking forward to a big year with your help. Our goal this year is two million dollars from all states to the American Medical Education Foundation. The past year saw us over the one million mark.

---

* Chairman, Medical and Chirurgical Faculty Committee to Cooperate with the American Medical Education Foundation.

In general, mail solicitation proved the least effective and person to person solicitation plus personal appearances at nine of our twenty-two component societies by the chairman seemed to be of greater value. Heavy emphasis will be given this type of approach in enlarging our committee this year. Correspondence has been maintained with the presidents of all twenty-two societies with a courteous response from most. Thanks goes to those societies who were hosts at dinner to committee speakers.

May I still suggest that eighty-seven contributors to such a vital project in behalf of the entire medical profession is still a small number in a society that acknowledges over eighteen hundred members. We need lots more of the loyal supporters such as Dr. Harvey B. Stone who will receive the American Medical Education Foundation Award of Merit for his generous contributions.

MEDICAL DIRECTOR APPOINTED

The Maryland Hospital Service, Inc., announces the appointment of Dr. R. Walter Graham, Jr., as Medical Director of the Blue Cross and Blue Shield Plans effective June 1, 1953. Dr. Graham succeeds the late Dr. Richard F. Kieffer.

Dr. Graham will continue in private practice serving the Prepayment Plan on a part-time consulting basis. He also will continue to serve as Chairman of the Medical Advisory Committee to Selective Service.

VACANCIES IN RESIDENT STAFF AND ADMITTING OFFICE

There are several vacancies in the resident staff in Internal Medicine, Pathology and Radiology, at the Veterans Administration Hospital, Fort Howard, Maryland. There is also a full time position vacancy for an Admitting Officer. The salary range for residents is $2640 to $3300, per annum, while that for full time positions is $5500 to $12,800, depending upon training and experience.

Interested physicians should inquire of Dr. M. H. Travers, Chief of Professional Services, Veterans Administration Hospital, Fort Howard, Maryland, for further details.

Scientific Papers

THE COLLAGEN DISORDERS*

LOUIS K. ALPERT, M.D.†

Definition

The term "collagen" refers to that material which lies between the connective tissue cells, the so-called "matrix" or "ground substance." It is the material which holds the cells together. In normal tissues, this intercellular material is not visible in histologic sections. However, in the group of disorders which we are discussing this morning the collagen becomes changed so that it takes on a deep pink stain, and resembles fibrin, hence the term "fibrinoid degeneration" is often applied to it. This is the primary or fundamental change which characterizes the collagen diseases.

Since this ground substance is present also in the walls of blood vessels, vascular changes play a prominent role in the pathological and clinical picture of the collagen disorders. In the small arteries and arterioles one sees, in addition to fibrinoid degeneration, a thickening of the wall, areas of necrosis, and infiltration of polymorphonuclear leucocytes, lymphocytes, eosinophiles and plasma cells. The cellular infiltration frequently extends outside the vessel walls to form the characteristic collar of perivascular infiltration. In the tissues around the blood vessels there is a proliferation of connective tissue, and often fibrosis in the later stages of the disease.

The *etiologic factor* which appears to be common to all of the collagen disorders is a hypersensitivity to chemical substances. In this are included bacterial proteins, particularly those of the streptococcus and possibly the tubercle bacillus, food proteins, horse serum, penicillin, and a number of organic and inorganic compounds, such as the sulfonamides and iodides.

I might say that the allergic basis for the collagen diseases is not unanimously accepted by all physicians who have studied them closely. The strongest exponent of the "pro"-allergic thesis has been Dr. Arnold Rich, of the Johns Hopkins Hospital. He has been able to produce lesions in rabbits with horse serum which have every appearance of periarteritis nodosa in some animals and of rheumatic fever in others. He has also demonstrated these lesions in autopsy material from patients who have died with reactions to sulfonamides, aspirin, iodides, thiourea, dilantin and horse serum. On the "anti" allergic side are Drs. Klemperer and Baehr, of Mt. Sinai Hospital in New York, who originally recognized the collagen disorders in 1941. Their feeling is that even though the histologic lesions in the various diseases are similar, one should not necessarily assume that the etiologic mechanism is the same in all. However, up to the present time the weight of evidence seems to be in favor of hypersensitivity as being the common factor in these disorders.

I will now attempt to describe for you the pathological and clinical aspects of the diseases which I believe should be included in the category of the collagen disorders, and some of the recommended therapy.

Rheumatoid Arthritis

The pathologic alterations in the joints begin with edema and inflammation, including the changes in small blood vessels such as I have described previously as characteristic of the collagen disorders. As the disease progresses, the synovial membranes which form the lining of the joints undergo proliferation, and as they grow across the joint surfaces, the cartilage is destroyed and resorption of bone occurs. As an indication of the generalized nature of this disease, it has been shown that biopsies of muscle will also show the interstitial and vascular collagenous abnormalities.

---

* Courtesy of the Maryland Academy of General Practice. Presented before this Association at its Annual Scientific Assembly, October 9, 1952, Lord Baltimore Hotel, Baltimore.

† Adjunct Clinical Professor of Medicine, George Washington University School of Medicine; Chief, General Medical Service, Veterans Administration Hospital, Washington, D. C.

In the clinical picture of rheumatoid arthritis, I would like to emphasize the early occurrence of fatigue, mild fever and loss of weight which may even precede the obvious joint changes. Subcutaneous nodules, often at some distance from the joints, are frequently found. The blood may show a mild anemia, and slight elevation of the white cell count and sedimentation rate. Valvular lesions of the heart should be looked for, since they have been found at autopsy, in various studies, to be present in from 25% to 65% of the patients.

From the therapeutic standpoint the salicylates have had the longest and greatest usefulness, and they are still the mainstay of treatment. They should be used in dosage up to tolerance, as high as 80 or 100 grains per day. Total body rest is of great value, but it should be combined with carefully used physiotherapy to prevent muscular atrophy. Many of you have undoubtedly used ACTH or cortisone in these patients with great improvement. There is no doubt that these drugs are very effective, but they must be used with great care because of the undesirable side effects which they produce. The minimal dosage which will produce a favorable effect is the one to use. Usually 25–75 mgm. of cortisone orally per day will provide adequate relief without side effects. One should not necessarily attempt to eliminate all symptoms with ACTH.

Very recently, in June 1952, a report regarding the use of phenylbutazone (Butazolidin) in rheumatoid arthritis appeared in the J.A.M.A. This drug is chemically similar to aminopyrine. It is not related in any way to ACTH or cortisone. The dosage is 200 mgm., given one to six times daily, depending on the response. In general, the clinical results with this drug have been favorable, but toxic reactions have occurred in over ¼ of the patients. These reactions, in order of frequency of occurrence, are nausea 14%, edema 12%, skin rash 4%, reactivation of peptic ulcer 3%, dizziness 2%, and anemia 1%. Whether this drug will become a permanent adjunct to the treatment of rheumatoid arthritis still remains to be seen.

Rheumatic Fever

I am sure that the classic picture of migratory arthritis and valvular heart disease in rheumatic fever is well known to you. One should also remember that pericarditis, pleurisy and pneumonitis occur frequently in this disease, sometimes as the initial symptoms. In children, abdominal pain may be a prominent feature, and often leads to a diagnosis of appendicitis, or other abdominal emergency for which surgery is performed. Anemia, leukocytosis and an elevated sedimentation rate are almost invariably present.

With regard to treatment, the use of large doses of salicylates, up to 150 grains per day in the adult, and proportional doses in children, has produced results which are equally as good as those seen with cortisone or ACTH. If the patient is unable to tolerate large dosage of salicylates, or, as occasionally happens in the severe cases, the response even to large doses is inadequate, then ACTH or cortisone should be used, with due care for the side-effects, the most important of which, in this instance, is the tendency to increased edema formation.

Disseminated Lupus Erythematosus

This is a serious disease, since it is almost invariably fatal in 1 to 2 years. It is much more common in women than in men. It is characterized by an erythematous macular eruption over the nose and cheeks, the so-called "butterfly" eruption, together with joint pains and swelling, fever, and weight loss. The heart is involved with tachycardia and a systolic murmur. The endocardium shows at autopsy a typical nodular endocarditis which used to be called "Libman-Sachs" disease. It is not the same as rheumatoid endocarditis. Pericardial, pleural and peritoneal effusions are common. The kidneys are often involved in disseminated lupus, and pathologically the so-called "wire-loop" lesion is seen in the glomeruli. The urine shows albumin and red cells. The blood count shows anemia, leukopenia and thrombopenia. The sedimentation rate is high and the albumin-globulin ratio is often reversed. Epileptiform seizures, due to involvement of cerebral vessels, are not uncommon.

The diagnosis can be established by finding the "L-E" cells in the bone marrow or peripheral blood. The "L-E" cell is a polymorphonuclear leucocyte which has phagocytized nuclei from other autolyzed leucocytes.

The most effective treatment of disseminated lupus erythematosis is the adequate use of cortisone or ACTH. The dosage must be high at the start, for example 300–400 mgm. of cortisone, or 150–200 mgm. of ACTH per day during the first few days. When the disease is brought under control, the dosage is decreased to the level at which symptoms begin to recur, and then it is kept at just above this level in order to keep the patient free of symptoms.

DERMATOMYOSITIS

Dermatomyositis, as the name implies, is an inflammatory process which involves the skin, subcutaneous tissues, and muscles. The lesions are non-suppurative, and no infectious agent has been isolated from them.

Clinically, the skin shows a localized dusky erythema and edema. The underlying muscle tissue is painful and tender, and as the disease progresses, muscle weakness and atrophy develops. Any portion of the body may be involved, not only the trunk and extremities, but also the face, eyes, pharynx and diaphragm. The joints and heart are rarely involved. The blood count may show eosinophilia and mild anemia.

Dermatomyositis is fatal in 50–60% of the cases in 1–2 years, death occurring from involvement of the respiratory muscles and diaphragm with secondary bronchopneumonia.

There are two types of therapy for this disease. One is with para-amino-benzoic acid (PABA), which is given in doses of 2 grams (30 grains) 3 times daily, and gradually increased to tolerance. As much as 12–24 grams (180–360 grains) every 24 hours may be necessary to achieve maximum results. The toxic effects which may occur are nausea, vomiting, fever and leucopenia. Improvement is gradual. Complete remission usually does not take place with this drug.

The other form of treatment is with ACTH or cortisone. The dosage varies with the severity of involvement, varying between 100–300 mgm. of cortisone, or 60–100 mgm. of ACTH daily. The response is difficult to predict, but most of the patients respond rapidly and have complete remission for prolonged periods.

SCLERODERMA

Scleroderma is characterized by the development of progressive tightness of the skin, which becomes smooth and waxy in appearance. The subcutaneous tissues become hardened, so that the skin cannot be lifted. Microscopically, the subcutaneous tissues show dense fibrosis, and the dermis is atrophic. Blood vessels in the skin and subcutaneous tissues are involved by the inflammation and degenerative changes mentioned earlier.

The first manifestations of scleroderma often resemble Raynaud's disease in the hands. The involvement of the face produces a mask-like expression with limitation in movement of the jaw, and difficulty in eating. The esophagus is often involved, with the production of a thickened, stiff wall, which may result in difficulty in swallowing. Movement of the joints of the hands and elbows become limited because of the immobility of the skin. In the late stages, the skin over the chest and abdomen is involved, which may lead to difficulty in breathing, which the patient describes as shortness of breath.

In most patients, fortunately, the disease progresses very slowly, and may remain stationary for years or may even regress spontaneously. In about 10–20% of the cases, however, the disorder continues slowly until the patient dies after several years because of starvation, due to inability to eat or swallow.

The treatment is similar to that of dermatomyositis, namely with either para-amino-benzoic acid, or ACTH or cortisone. The response to therapy, however, is different. PABA has a better effect in this disease, whereas cortisone and ACTH are beneficial only in the very early stages.

PERIARTERITIS NODOSA

This disease is essentially an inflammation in and around the medium-sized and small arteries, with necrosis, fibrinoid change and hyalinization of the walls, and perivascular infiltration with mononuclear, polymorphonuclear and eosinophilia cells.

The widespread involvement of the blood vessels produce variable and often puzzling symptoms. The constitutional symptoms are fever, tachycardia, weakness, and weight loss. The local manifestations may involve any organ, and I can only list the most common ones. Peripheral neuritis is quite common, as is also kidney involvement, with the manifestation of albuminuria and hematuria. Hypertension occurs in about half the cases. Asthma may be an early symptom. Episodes of abdominal pain, nausea and vomiting may simulate surgical emergencies. Skin eruptions, varying from urticaria to bullous lesions may occur.

The blood picture may give the clue to the diagnosis, since leucocytosis, eosinophilia and anemia are usually present.

The prognosis is rather poor, since about 50% of the patients die in 1–2 years, with either heart failure or uremia.

The only therapy which has any effect in this disease is cortisone or ACTH. The only drawback to this treatment is that, even when the disease is cured, paradoxically, the patient is apt to die. The reason for this is that when the inflammatory process in the arteries subsides, it is replaced by scar tissue, and as this scar tissue contracts, the artery becomes completely occluded. This leads to ischemia and necrosis of the organ supplied by the arteries so affected. Thus, for example, if the kidney is involved, irreversible uremia results. The physician must therefore exercise great caution in the use of ACTH or cortisone in the patients. It is best to use these drugs early in the disease, and the dosage should be started at a low level, such as 50 mgm. of cortisone or 20 mgm. of ACTH per day, and increased very gradually, depending on the response.

ERYTHEMA NODOSUM

This disease is characterized by an eruption of circular, red, raised warm and tender lesions, most frequently over the legs, but may appear over any part of the body. They often come and go in crops, and are accompanied by fever and joint pains.

The eruptions of erythema nodosum are now looked upon as a manifestation of sensitivity, and occur in a wide variety of diseases, including hemolytic streptococcus sore throat, syphilis, gonorrhea, ulcerative colitis, coccidiomycosis, sarcoidosis, and meningococcal infection. Erythema nodosum has also been observed following the administration of iodides, bromides, sulphonamides, quinine, atropine, and the barbiturates. In Europe, it has been considered as being a manifestation of tuberculin sensitivity.

Before the eruption appears, there is usually a period of headache, malaise, anorexia, muscle and joint pain and fever. In a large proportion of the patients there is rather striking enlargement of the lymph nodes in the hilar regions of the lungs.

The duration of illness from erythema nodosum is usually about 3–4 weeks.

The treatment is largely symptomatic. Any drug which the patient may have been taking prior to the onset of the illness, which might be responsible, should be discontinued. The antibiotics are of little value. Salicylates in large doses are very helpful. In severe cases, ACTH or cortisone, carefully used, will produce prompt relief, but must be maintained during the entire illness, since relapse may occur when the drug is discontinued.

ERYTHEMA MULTIFORME

This is an acute disease, with skin and mucous membrane lesions which may have a variety of appearances, either macular, papular, vesicular or bullous. The most characteristic lesion shows 2 or 3 concentric rings of discoloration, the so-called "iris pattern."

The eruption of erythema multiforme appears most frequently on the extensor surfaces of the hands and feet, but may involve the palms, soles, extremities, trunks and face. Severe involvement of the mucous membranes of the mouth may occur, and when this is associated with ulcerations on the glans penis or vulva, it is called the "Steven-Johnson syndrome."

Erythema multiforme is a self-limited disease, lasting 2–3 weeks, but it may recur to a more severe degree. Here again, ACTH and cortisone may ameliorate the disease.

PEMPHIGUS

This disease may be considered an extremely severe form of erythema multiforme. The skin is covered by large, purulent appearing bullae filled with yellow fluid. When they break, the underlying tissue is red and raw. The membranes of the mouth are covered with painful ulcerated lesions. Pemphigus is a fatal disease in most instances, even though it may continue for several months. In the past no therapy has been of any value, but now the disease can be brought rapidly under control with large doses of cortisone, 600 mgm. per day. This can be gradually reduced to a maintenance level, which is usually about 150 mgm. per day. After several months, the dose may be further reduced, but if relapse occurs, it should be raised again to high levels.

ANAPHYLACTOID PURPURA

In this disease one sees the localized development of urticaria, edema and hemorrhage, in association with drug sensitivity, serum sickness and other allergic disorders. When the joints are also involved it is called Schonlein's purpura. When the gastro-intestinal tract is involved, it is called Henoch's purpura. Occasionally the kidneys alone may be involved, and lead to an erroneous diagnosis of acute nephritis, because of the hematuria.

THROMBOANGIITIS OBLITERANS

In this disease, the small arteries and veins of the lower extremities are involved, producing the characteristic intermittent claudication on walking. Occasionally the mesenteric, renal, coronary or cerebral vessels may also be involved.

The etiologic factor is sensitivity to tobacco, and the only satisfactory treatment is the complete elimination of smoking.

LOEFFLER'S PNEUMONIA

This is an acute disease, with fever, cough, and infiltrations in the lung. The characteristic feature is the marked eosinophilia in the blood. The pulmonary lesions are due to eosinophilic infiltration. Recovery usually occurs in a few days, without therapy. If the disease becomes prolonged, ACTH or cortisone can be used to produce rapid clearing.

CORTISONE AND ACTH

Finally, I would like to say a few words about the use of cortisone and ACTH in general, since I have repeatedly mentioned the value of these drugs in the collagen disorders. These are powerful hormones, and must be used with clear recognition of the hazards of the "over" physiologic effect which they produce. I may say first, that doses of 25–50 mgm. of cortisone, and of 10–20 mgm. of ACTH have little deleterious effect. Beyond these levels, the clinical features to watch for are edema, due to salt retention, muscle weakness, due to loss of potassium and protein, and mental changes, such as insomnia or depression, or occasionally a manic phase. Less frequently, elevation of blood pressure and a rise in blood sugar may occur. Increase in fat around the face and abdomen, and acne of the skin are very common.

In order to prevent the edema the patient should be placed on a *completely* salt free diet, including no salt in the cooking. The administration of potassium chloride, 15 grains 3 or 4 times per day will diminish the loss of potassium. With regard to the other changes, only a reduction or elimination of the drug will revert them.

The decision when to use cortisone or ACTH should be made with care. In the serious or fatal diseases, such as lupus erythematosus or pemphigus the physician must use the drugs in large doses, and consider the side effects as of lesser importance. In the less serious diseases, the dosage should be kept as low as possible, at the level which will just produce the desired symptomatic benefit, and be discontinued as soon as feasible.

SYMPOSIUM ON TRAUMA*

INTRODUCTION

PAUL F. DUE, Esquire, *Moderator*†

Ladies and gentlemen, as you know, this symposium is sponsored by the Medico-Legal Committee of The Medical and Chirurgical Society of Maryland, The Bar Association of Baltimore City, and The Maryland State Bar Association. The subject is "Trauma and Its Relation to Disease." And this, incidentally, is the fourth of such symposia.

The panel tonight consists of Dr. Russell S. Fisher, Dr. Joseph L. Lilienthal, Dr. Eugene Meyer, and Judge Emory H. Niles. Each of these gentlemen will discuss this question from the standpoint of his own particular specialty. At the conclusion of the discussion, there will be a question period, in which each of the four participants will submit questions to some of the others.

You have been provided with pencils and paper, and you are invited during the course of the discussion to frame certain questions which may occur to you. And after the last speaker has concluded his talk, these questions will be collected and submitted to the various speakers.

Now, the first speaker will be Dr. Russell S. Fisher, who is presently Chief Medical Examiner of the State of Maryland, Professor of Legal Medicine and Head of Division of Legal Medicine, Department of Medicine, University of Maryland Medical School and Lecturer in Forensic Pathology, Johns Hopkins University Medical School.

Dr. Fisher holds degrees of B.S. from the Georgia School of Technology and M.D. from the Medical College of Virginia. He will discuss the subject "Trauma and Its Relation to Disease" from the viewpoint of the pathologist.

---

* Arranged by the Joint Committee on Medicolegal Problems of the Baltimore and Maryland Bar Associations and the Medical and Chirurgical Faculty, under the auspices of the Symposia Management Subcommittee. Presented Friday, October 24, 1952, Osler Hall.

† President, Bar Association of Baltimore City.

VIEWPOINT OF THE PATHOLOGIST

RUSSELL S. FISHER, M.D.*

Mr. Chairman, and ladies and gentlemen:

The pathologist in his role as the last medical man to arrive on the scene, at least in the fatal cases which come to his attention, is given the job of determining in a factual way the actual nature and cause of the death. In this State, where the law makes it mandatory that all deaths due to violence be reported to the Medical Examiner, it is he who, for all practical purposes, must acquire the information which will later be necessary for the courts as they ponder the relative importance of trauma and the natural factors as causes of a death. The Medical Examiner must, furthermore, be able to interpret his findings in an expert manner in all of those deaths which he has studied, in order that the information he has acquired will attain the maximum of usefulness in settling litigation. It is in those deaths in which injury combines with disease to produce a fatal outcome that expert opinion, based on careful study of the case and of precedents in the experience of others, is most useful in resolving an issue.

Those cases may be considered in three categories:

I. The medical situation
  (a) where pre-existing medical disease complicated by intentional or negligent injury leads to death.

A case to illustrate this type of situation is that of an elderly filling station operator suffering from heart disease, but able to do his daily work, who was assaulted by a young man who wished to buy gas. The altercation occurred as the result of the customer wanting to buy gas after the station was closed. During the struggle, the operator was struck on the head with a nozzle on the end of the gas hose. The assailant fled, and within a minute or two after his departure the elderly man struggled out in the street, collapsed and was dead when aid reached him.

Post-mortem examination showed that the injuries to the head were superficial and that the medical cause of his death was hardening of the arteries of the heart.

The testimony in the case included the opinion that the precipitating cause of his death at that time was the struggle and the blows he sustained to the head during the altercation.

(b) The legal principle

Disease plus injury—the defendant's act must have been a direct contributing cause of the death, but it need not be the sole cause of the death. This was stated in State vs. O'Brien, 81 Iowa 88.

(c) A working philosophy

Disease plus injury—Reduce the group by the questions—(1) was injury truly a contributing cause to the death. If the answer is no, then no case. And (2) was injury likely to have been fatal even without disease. If so, the case is actionable without regard to disease. And finally, if answer to (1) is yes and (2) is no, then the case should be prosecuted. And usually it is a manslaughter case.

II. The medical situation
  (a) Where death is due to medical complications of ordinarily non-fatal injuries.

As an illustrative case, I may cite the young man who was shot in the thigh by an assailant. He received first aid for his gunshot wound and then left the accident room of the hospital, only to return several days later to another hospital, where he was admitted and surgical removal of the bullet accomplished.

It was noted at the time of the operation, that the bullet had caused injury to the veins of the thigh. Nine days later, despite an apparently uneventful recovery, the patient sat up in bed and dropped dead.

---

* Chief Medical Examiner of the State of Maryland

The post-mortem examination showed that the cause of his death was pulmonary embolism, with the fatal clot having formed in and been detached from the veins injured by the bullet.

(b) The legal principle

Medical complications of injury. Where the defendant inflicts an injury which brings on a diseased condition from which the injured person dies, the defendant is guilty of homicide. (Powell vs. State, 13 Tex. App. 244) The defendant is responsible for the *natural* consequences of his wrongful acts.

(c) A working philosophy

Despite the "misfortune" of having his victim die when better luck might have prevented his "clot in the lungs" or his "meningitis" from a fractured skull, the assailant is subject to prosecution. His luck can't be as bad as was his victim's.

III. The medical situation

(a) Injury followed by therapeutic misadventure and death.

A typical case is that of an individual who sustained injuries about the elbow of a gunshot wound sustained when he was assaulted by another man. He was admitted to the hospital and several days later became disoriented and confused. The tentative diagnosis of "lock jaw" was made.

Instead of the usual treatment of "lock jaw," the physician in charge of the case elected to administer lock jaw anti-serum into the spinal fluid and introduced a needle into the cisterna magna at the base of the brain. The injured man struggled while the needle was in and it punctured the brain stem, causing death within a few hours.

Since this type of medical treatment is not considered the standard medical treatment but was, instead, an unusual and, in retrospect, dangerous type of procedure and since the original injury might well have been recovered from, the death was considered due to therapeutic misadventure, which was in this case, of course, fancy terminology for a medical mistake.

(b) The legal principle

Injury plus therapeutic misadventure. Where the defendant inflicts a mortal wound and then the wound is treated medically and such treatment results in death, the defendant is guilty of homicide, but if the wound is not mortal in itself, and the death results solely from the improper medical treatment, the defendant is not guilty of homicide. (Parsons vs. State, 21 Ala. 300)

(c) A working philosophy

Injury and therapeutic misadventure. Here the first question is usually—Is there cause for action against those making the medical mistake? If so, the assailant's contribution is non-actionable. If not, the assailant must be charged and a full explanation of the "misadventure" given the court or jury, who must weigh the "odds," and if they are as wise as Solomon, justice will be done.

These three variants include about all of the combinations of trauma and disease to be considered in criminal cases.

In the non-criminal cases, the medical situations are essentially the same, but the question is altered, in that the issue is one of evaluating the damages sustained or the award to be made, for example, in the case of industrial accidental injury. The compensation laws provide for awards in cases of disability or death sustained by employees resulting from an accidental personal injury "arising out of and in the course of his employment without regard to fault as a cause of such injury." Since this is the wording of the law in the matter, it is clear that compensation is available in all of the above cases. Obviously, however, arbitration must frequently be resorted to in the questionable cases.

In conclusion, and in summary, the pathologist has the duty to collect facts and be able to interpret them for the court in an intelligible fashion. He should strive at all times to be a neutral observer rather than to be partisan in any given case.

Mr. Due: Thank you, Dr. Fisher.

How lawyers would like to play around with that term "misadventure." Anyway, I don't know what I would do with it.

Anyhow, our next speaker is Dr. Joseph L. Lilienthal, Jr., who is Professor of Environmental Medicine and Associate Professor of Medicine of Johns Hopkins University. He is also a physician with the Johns Hopkins Hospital. Finally, he is consultant to the Secretary of Defense, Surgeon General of the Army, the Office of Naval Research and National Science Foundation. He holds the degrees of B.S. from Yale University and M.D. from Johns Hopkins University.

Dr. Lilienthal will discuss "Trauma and Its Relation to Disease" from the standpoint of an internist.

VIEWPOINT OF THE INTERNIST

JOSEPH L. LILIENTHAL, Jr., M.D.*

My assignment requires of me a discussion of Trauma from the Internist's Viewpoint. I would prefer to retitle it as Trauma from *One* Internist's Viewpoint and thus avoid involving my colleagues in some of the heresies which I plan to propound. As has already been and doubtless will be emphasized, this is a murky business with light visible only at the very periphery of a complicated problem. Perhaps we might start with the standard definition of trauma as a wound, an injury, a shock or the condition resulting therefrom. I would like to emphasize the word *injury* and to point out that by a reasonable extension of the definition of injury we may include these minor injuries received over the years, which when they are summated, we recognize as aging. This extension of the definition has been made to stress the fact that although the traumatic event or agent may be relatively simple the person who is traumatized is incredibly complex. And this complexity involves all phases of age, heredity, previous life, as well as state at the time of injury. It is because of this complexity that the relation of trauma to disease must be considered in a partial analysis. There must be many ways to do this but the one I have adopted seems especially suited to those aspects of the problem which I should like to discuss with you.

But first let us consider what I believe to be certain fundamental similarities and also differences in the approaches of the law and of medicine. Both disciplines require answers to the following questions:

(1) Is there causal relationship between the trauma and the disease or handicap?

(2) What is the degree of handicap?

(3) For what part of the handicap is the trauma responsible?

It appears to me that the answers required differ significantly with respect to one feature, that is time. By its very nature the law must arrive at the best and fairest answer *now*, taking note of what is known *now*, and arriving at a decision which then terminates the problem *now*. Medicine, by contrast, is so rarely ever capable of or willing to answer the question *now* because so many of the facets of the problem are unexplored, are unknown, and those which appear to be known are constantly changing. Part of this property of constantly changing is inherent in biology which views the interaction of an organism (in this instance man) and its environment as occurring in a continuum of time. Thus the results of a reaction between man and the forces which play on him may take months and years before they appear above the clinical horizon. And because of the wide variation among men, whether or when the reaction will become detectable is a matter of the widest variability itself. To exemplify the difficulties which face us and to reveal the imperfect state of the art and science of medicine I should like to consider the relation of trauma to disease in the cardiovascular and respiratory systems in terms of the three basic questions outlined earlier and for which both the law and medicine require answers.

---

* Professor of Environmental Medicine and Associate Professor of Medicine, The Johns Hopkins University.

The first question we have set ourselves revolves about causal relationships. These may be set out in a spectral array ranging from traumatic episodes which are manifestly the immediate cause of the injury or disease to occurrences which are almost certainly not related to any recognized trauma. Perhaps we might begin with examples at the extreme edges of this spectrum.

A penetrating wound of the heart or great vessels, or the passage of an appropriate electrical current may produce structural or functional cardiac changes leading to death. Acute exposure to several toxic gases, as for example chlorine, cadmium or carbon monoxide, may result in death for which the causal relationship is crystal clear.

By contrast the quiet death during sleep of the nonagenarian who is discovered subsequently at autopsy to have an infarct of the myocardium is held generally not to be attributable to any trauma more specific than the passage of 90 years. Similarly, the aging sedentary person whose mild shortness of breath is discovered to be associated with moderate senile emphysema is not thought usually to be suffering from the results of any specific trauma. As an aside one might point out that even these contemporary working conclusions may someday be altered drastically; for not every aged person suffers from atherosclerosis or emphysema; perhaps trauma, minor and repeated, may indeed play a role in the development of these diseases. The reported observation that arteriosclerosis virtually does not exist in the native Chinese suggests that these examples which I have given may not be as applicable as current beliefs now hold. Nevertheless, I believe few physicians would take exception to these examples of obvious causal and of non-causal relations between trauma and disease.

Let us move in from the extremities of the spectrum. Instead of penetrating wounds of the heart consider the sequelae of non-penetrating contusions of the chest. Under conditions of extraordinary force and violence rupture of cardiac musculature, valves or chordae tendineae has been seen. After impacts of lesser force persons surviving the blow have displayed symptoms, signs and corroborative diagnostic evidence for establishing the occurrence of a myocardial infarction. In some instances the apparent force of the blow is of such small significance as to make it difficult to be sure that the relationship is more than chance. There is little comfort or support in the well-documented knowledge that at least half of the clinical onsets of myocardial infarction occur during a period of rest or even sleep because in a small percentage, contrariwise, the association of infarction with severe exertion seems inescapable.

Now, for an example of the uncertainty arising from lack of specific information. Recently, industry has noted an unusually high frequency of cardiac disease and death among workers exposed to fumes of antimony. That a causal relation may exist is suggested by the epidemiological observations as well as by animal experiments in which myocardial damage has been produced by experimental exposure to antimony compounds. A few years before, the "expert" in such matters could have said fairly no more than, "We are not aware of any association of heart disease and exposure to antimony."

And again consider an example of how information gathered with care may be misleading. I would imagine that most of you are aware that exposure to dusts of beryllium, used formerly in the phosphors of the familiar fluorescent lamp, produces chronic progressive granulomata of the lung, leading eventually to death. Early studies of the toxicity of this metal, carried out in the accepted manner led to the conclusion that the degree of exposure ordinarily encountered in industry did not constitute an occupational hazard. Nowadays, we know that on the contrary the inhalation of minute amounts of beryllium as a dust or fume may lead to tragic consequences.

Another example of the constantly changing pattern of our knowledge is the very recent demonstration that among men exposed to certain salts of chromium the incidence of carcinoma of the lung is many-fold that of their fellows in other activities. Only a few years ago the expert toxicologist or industrial physician could not have accepted on the available evidence this causal relationship which subsequent studies have made inescapable.

Let us turn now to our second question regarding the degree of handicap induced by the trauma and its consequences. The difficulties encountered in assessing handicap might be illustrated by considering the man with a traumatic loss of both legs who by means of adequate prosthetic legs carries on an independent, productive and active existence. Compare the man who, following a trifling injury to his hand, is utterly incapacitated for work because of persistent bizarre pain in his hand and arm. By all intuitive and common sense one might have predicted on the basis of the trauma that the degree of handicap would have been reversed in the two examples. One may summarize the reasons for the difference by saying simply that these are two different men, that personality and motivation are potent modifiers of handicap and that despite the contributions of many students, we still lack quantitative measures of these important factors. Thus the coal-miner with silicosis may be studied at great length by all the newer technics of assessing pulmonary function; yet in the end the determination of what this man is capable of doing may result entirely from what he is willing or wants to do.

Experience in any specific test of function leads most persons to realize that the test is only approximate. For example, the more experienced the cardiologist the less weight he places on the electrocardiogram as a *measure* of disease and on its second-order derivative, the degree of functional handicap.

Now to consider the third question of what role the trauma plays in the handicap or disease. This kind of judgment sometimes has assumed the cloak of quantitative respectability by expressing itself in terms of a percentage disability. A case in point is the recurring need for assessing disability in terms of its multiple causes in elderly bituminous coal miners who are discovered to have silicosis, pulmonary emphysema, more or less arteriosclerosis of their coronary arteries and who have recently lost employment because of economic factors beyond their control. Of these various factors the role of silicosis is paramount because it is today a compensable disease. Frankly the problem of unravelling this tangle is almost insoluble by means of presently available analytical technics. The best that can be offered by the physician is an intelligent guess. It is likely that this guess frequently is not far off the mark but we would be somewhat less than candid if we claimed much more than that this is the best possible guess.

Earlier it was hinted that the person who is traumatized is incredibly complex and that the degree of handicap was modified by the personality. Even more forcibly I should like to underline a modern conviction that the progress of the disease process itself is inextricably linked with the emotional processes of the person,—indeed, they are one.

How then do we stand? We are forced to arrive at some reasonable compromise between what the law requires for an immediate answer and what medicine can provide. I have chosen to emphasize this evening the fact that the decisions required of medicine by the law must all too often be based on inadequate data obtained by inadequate methods. I would be unfair if at the same time I failed to point with real pride to the many things which medicine does know and to express my firm conviction that the growth of biological knowledge applicable to the needs of the law is advancing by geometrical progression.

MR. DUE: We thank you, Dr. Lilienthal. Our next speaker is Dr. Eugene Meyer, who holds the degrees of A.B. from Yale University and M.D. from Johns Hopkins University. He served as Interne and Assistant Resident in Medicine at Johns Hopkins Hospital, as Psychiatrist in an Air Force convalescent hospital, as Resident Psychiatrist at Henry Phipps Psychiatric Clinic at Johns Hopkins Hospital, and is now serving full time on the staff of Johns Hopkins Hospital, in charge of a psychiatric liaison service in the Department of Medicine.

He will discuss "Trauma and Its Relation to Disease" from the standpoint of the psychiatrist.

VIEWPOINT OF THE PSYCHIATRIST

EUGENE E. MEYER, III, M.D.*

Mr. Chairman, ladies and gentlemen:

My dictionary, with apologies to Dr. Lilienthal, has two definitions of the word "trauma." 1.) "a wound or external bodily injury in general; also the condition caused by this, traumatism." 2.)—(Psychoanalysis)—"a disturbing experience which affects the mind or nerves of a person so as to induce hysteria or psychic conditions; a mental shock."

The psychiatrist's point of view may be relevant, I assume, in both circumstances. In physical injury his assessment might be called for when the injury is accompanied or followed by unusual or abnormal psychologic response. An emotional trauma or shock due to some accident or other sudden event which is followed by a relatively enduring pattern of disability in psychologic function—this is the traditional stamping ground of the psychiatrist. You notice already that I do not speak of a traumatic neurosis and that I carefully avoid saying an emotional trauma or shock produces a psychologic disability or a state of neurosis. In this difference lies the content of what I wish to elaborate further.

A simple way to put it is that both physical and psychologic trauma take their toll of the individual's health and produce some disability, however temporary or minor. The psychiatrist tries to distinguish, however, between the expected or average or normal response to a given trauma or acute stress and those responses which are not understandable, either in their quality, their intensity or their duration, in terms of the acute stress or trauma. This introduces, in the field of psychiatry, the same spectrum of response that Dr. Lilienthal spoke of in the field of organic pathology. At one end of the spectrum little trauma is followed by a marked neurotic disability; at the other end severe trauma is followed by little or no neurotic disability.

I feel certain that the field of trauma as it relates to psychiatry is too large to trace out even in a long fifteen minutes, so I will simply make some general statements that I propose in relation to these matters, and will then elaborate on what I believe are their most important aspects.

---

* Assistant Professor of Psychiatry and Assistant Professor of Medicine, The Johns Hopkins University School of Medicine.

1. The term traumatic neurosis is a poor term and should be discarded.

2. There is no known correlation between the severity of a physical injury or trauma and the development thereafter of a neurosis.

3. There is no qualitative difference in the clinical picture of neurotic reactions following physical trauma, neurotic reactions following emotional trauma and neurotic reactions in which no prior trauma is obvious.

4. Where a physical or emotional trauma is followed by an emotional upset that persists and then becomes a source of disability in itself, there is invariably evidence of tendencies to such upset or of frank neurotic reaction prior to the trauma.

5. Events following a physical or emotional trauma may be of critical importance in determining whether a neurosis ensues.

6. Final and especially favorable settlements of claims in litigation can produce definite improvement and at times dramatic improvement in the clinical picture of neurosis following trauma. I have no personal experience with such events, but it is so universally mentioned that I pass it along for what it is worth[1-5].

7. There is evidence accumulating, both statistical and individual, that there is such a thing as an accident prone individual. This is a complex matter, but it would appear that self-destructive and self-defeating tendencies in an individual can express themselves by actually bringing about seemingly accidental injury.

The term "traumatic neurosis" in the light of present knowledge is a poor term. Historically it is derived from the late nineteenth century point of view. It was then felt that trauma shook up the molecular arrangement of the brain and spinal cord in such a way as to produce the disorder in behaviour and mental function called neurosis. If there is some truth in such a theory, it is yet to be verified. Damage, through trauma, can occur to the central nervous system and produce impairment in neurologic and psychologic function. These injuries are not at all necessarily followed by neurosis, however, if properly diagnosed and treated. Analogous to this term "traumatic neurosis" is that of "shell-shock" in World War I—a term used to cover everything from contused wounds of the head to purely neurotic reactions to the stress of combat, actual or even anticipated. Because of the experience in World War I, medical thinking in the 1920's had already passed from the concept traumatic neurosis to that of "posttraumatic neurosis," to use Catton's term,[1] or to "neurosis following accident," to use Foster Kennedy's phrase[6]. Dr. Lewellys F. Barker, in 1927, put it succinctly when he said, "Everyone has been impressed with the fact that the most severe nervous and mental results have often been ascribed to the injuries that have seemed the least severe, whereas violent injuries to the head and spine are not infrequently recovered from without the development of any clinical picture similar to 'traumatic neurosis.'"[7]

This leads us to the second general statement, that there is no known correlation between the severity of the physical injury and the development thereafter of a neurosis[8]. This was abundantly confirmed in World War II, when we saw different people experience the greatest vicissitudes in the way of physical injury, disease and the stress of combat, with a wide variation in personal responses and in capacity to function under these stresses. We saw also neurotic and psychotic breakdown severe enough to necessitate discharge from military service during the first weeks of basic training—that is, a maximal response to minimal stress.

The fourth and fifth propostions deal with the importance of the person's life experience prior to and following the trauma, as they determine a fortunate or unfortunate outcome to any single traumatic event. Of course, the severity of physical trauma is of importance in the outcome. There is the initial stage of acute shock, pain, anxiety and confusion. There is always a psychologic problem in coping with the results of injury, especially severe injury. To mention only a few, there are the problems of physical immobilization, hospitalization and its expenses, the loss of satisfaction in work and the feeling of being a productive person. There is the threat to security of the family and a fear of never getting well or of regaining mastery of one's environment to the extent that it existed before. But I think the situation of severe injury is not the area of confusion for the physician or the jurist, and I might add, for the patient himself. The area of difficulty is more in situations of little or no demonstrable residual of physical damage, with much persistent disability for normal living. This is true, I think, whether or not the matter of compensation or litigation is involved. It is particularly in such patients that one must seek the facts of the patient's or client's past experience and examine his current response to trauma, in the light of past reactions to other traumas or other stresses.

I must emphasize here again the limits of certainty within which the psychiatrist operates. They do not cramp his style so much or so often when he is operating as a therapist, but they sometimes make him feel like a bit of a fool when someone asks him a simple question about what has caused what and then seems to want a simple answer. To understand, for example, a current reaction of despair, depression, overt anxiety symptoms, hopelessness and chronic resentment following a trauma, the physician needs to know how much of the same feelings the person has experienced in the past and what were the significant experiences and the significant people in his life, past and present, that might shape up and perpetuate such reactions. It is only in this way that the personal meaning to the patient of his injury and disability can become clear. I suppose, too, it is only in this way that one can come to understand the occasional all-consuming quest for monetary compensation above everything else, including health itself.

One word about events following a trauma. It seems universally agreed that the best remedy for the so-called traumatic neurosis is its prevention. The point at which opportunities for prevention occur is immediately following the physical injury or the emotional trauma. In the military experience with combat reactions or acute combat neuroses, the effectiveness of treatment was high immediately after the occurrence and diminished as the time increased between onset of symptoms and treatment. This fact was so important that it resulted in psychiatrists being assigned to more and more forward units in World War II. I gather from reports the same policy has been followed in the war in Korea. The social importance of this can be realized in the fact that neuropsychiatric defects and disabilities have been the greatest single loss of manpower in the military service. The presence of psychiatrists operating in or near front line troops has remarkably increased the percentage of men returned to duty, and especially to combat duty.

In the civilian setting prevention seems to involve the same principles. Thorough medical investigation and rapid institution of an adequate regime of medical treatment are the essential factors. An adequate regime includes not only the diagnosis and treatment of the physical damage, but understanding of the threat to personal security and to self-esteem involved. Once a neurotic syndrome of symptoms is fixed, and particularly when compensation or pensions become involved, the physician's therapeutic program meets defeat, or at best gets a low priority rating in the patient's current scale of values. It would also seem from the medical literature that fair and speedy decision in the matter of financial compensation could also be thought of as preventive of neurosis. Here may be an area of both cooperation and conflict between physician and lawyer. The physician tries to assist the patient in his inner threat to security. The lawyer assists him in the external sources of his insecurity. But the physician cannot definitely predict an end to neurotic reactions. The jurist might feel that the case should remain open or settlement deferred until time has passed and the eventual outcome ascertained. As time passes the physician's treatment in these cases meets no success. Some physicians have therefore strongly endorsed the principle of lump sum settlement[1]. At any rate, it might be well for the lawyer and jurist to consider that there are cases in which delay in settling claims can be more of a liability than an asset to the patient's future.

The matter of accident proneness was the last proposition I made. I believe there is more than one route by which self-destructive and self-defeating tendencies can bring on a seemingly accidental injury. One route, I believe, is via fatigue states. Accident rates go up as fatigue increases. A person who drives himself constantly through neurotic compulsion into fatigue states simply spends more time in his life in a physical state conducive to accidents. Another route of self-injury is illustrated by a patient I came to know. He had operated a machine without accident for three years and on one morning suffered a crushing injury of a finger, resulting in amputation. The patient himself noticed that he was nervous that morning, because at 2 P. M. he was to report for his Selective Service physical examination. The psychiatrist cannot prove any connection between the two events, but in people better studied we have come to see that accidents can be felt as an avoidance, through a minor catastrophe, of a threatened major catastrophe. The sad fact, of course, is that the major catastrophe may be less of a real threat than something felt by the patient as real.

In closing I would like to raise a problem to which I know no answer, but which needs, I think, collaboration between our two professions. A single physical or emotional trauma can aggravate a previously existing state of neurosis. If compensation up to the maximum indicated by subsequent disability is to be awarded for such aggravation, what results will this have on employment practices? The Veterans Administration as well as all of us in the field of psychiatry are interested in having more rather than less employment opportunities open to those who have been treated in hospitals for mental illness. If an employer is to be held liable for aggravation of pre-existing neurotic states due to accidents or other stresses on the job, will he not be justified in tightening up rather than liberalizing his pre-employment examination and exclusion practices? This same question may also apply to any chronic illness which has the possibilities of aggravation as a result of physical or emotional trauma.

MR. DUE: Thank you, Dr. Meyer.

Our last speaker is the Honorable Emory H. Niles, who has his degrees of B.A. from Johns Hopkins University and B.C.L. from Oxford University, and L.L.B. from the University of Maryland. Judge Niles has been a Lecturer in Medical Jurisprudence at Johns Hopkins Medical School from 1948 to date. He was in the private practice of law from 1920 to 1938, and he has served with distinction as a Judge of the Supreme Bench of Baltimore City since 1938.

Judge Niles will discuss the subject "Trauma and Its Relation to Disease," from the standpoint of the lawyer and jurist.

VIEWPOINT OF THE LAWYER AND JURIST

Judge EMORY H. NILES*

Mr. Chairman, ladies and gentlemen.

There seems to be some competition here on the question of who is the last man. I think I win. It is I who hear Dr. Lilienthal tell why he may die, Dr. Fisher tell why he did die, Dr. Meyer speculate on the psychological or psychiatric implications of death; but I get them all last.

What I have to say will not be erudite, and it won't be news to lawyers.

Dr. Fisher in his talk dealt with both criminal and civil matters; I expect to confine myself to civil matters.

The subject tonight is "Trauma and Its Relation to Disease." I am completely incapable of discussing that subject. It seems to me that the only light that I can throw on it is to outline to the doctor some of the difficulties of the lawyer, in other words, what the lawyer wants to know about trauma and its relation to disease and how the lawyer is informed about the relation between a particular trauma and a particular disease at a particular time. I realize that that aim involves perfection. The other speakers have mentioned their inability to give exact answers, and, of course, we are all familiar with that situation. That is one of the troubles of the doctors. But it is also one of the troubles of the lawyers.

One of the most basic difficulties in this subject arises from the lack of understanding in each profession as to what the other is trying to do and how it is going about it. In contemplating the medical profession and the legal profession for some years I have observed not only that each has its vices and each has its virtues, but that every one of the vices of one profession is reflected in the vices of the other, and so also is every one of the virtues. There are vested interests in each profession. The doctors have their quacks; we have our shysters. The doctors have their handshakers; and so have we. Doctors have their ignorant men making piles of money, and so have we. The doctors have their learned men barely making a living, and so have we. There are some disagreeable lawyers; I will leave it to you to finish that sentence.

Now, in what kind of setting or framework do these medical questions come up to us lawyers? I remember that towards the end of the war I was trying a case in which the operator of a gasoline tank wagon had gone to a wholesale filling plant, where there were valves overhead operated by ropes that hung down. The operator had to climb up onto the tank wagon, reach up to get the rope, put the pipe into the inlet on the tank, and pull on the rope in order to open the valve. This driver pulled; the rope broke; and he fell and was injured.

The problems for the lawyers were not merely medical. The defense in the case was, first, that the man was careless; second, that the reason the oil company had provided a rope instead of a chain, which they used to have, was that during the war chains were unobtainable, since metal was on priority, and they had to use ropes; and third that although the driver might have been hurt, he had gotten well, that the x-rays were entirely negative, and there was really nothing wrong with him if only he wanted to be well.

I cite those facts simply to indicate the particularity and individuality of each case that comes before us. The medical problem is only one problem that is involved; but, of course, it is a vital problem. If the man had not been injured, there would not have been any case; but the nature and the extent of the injury is vital. What statistics might show about other cases is not vital, and it does not make any difference. It does not make any difference to the doctor whose fault it was. The matter of fault makes an immense difference to the lawyer and to the litigant, since it will control the outcome of the case, whether it is a ten dollar case or a ten thousand dollar case. All these considerations must be applied in specific cases. The medical questions which we must decide are mixed up with legal problems, which are just as complicated as the medical problems.

---

* Supreme Bench of Baltimore City.

Where do the doctors come in? The doctors come in usually as expert witnesses. And what is the Court trying to do? If some of the less sympathetic members of the medical profession should express their views, I think they would be that the lawyers are trying to confuse the doctors, and the judges are helping them out. That might be what happens in practice; but in theory, of course, there is no doubt about what the Court is trying to do. It is trying to ascertain the truth; and it is trying to get at the truth in exactly the same way that the medical men try to get at the truth in the laboratory. Perhaps that is an overstatement, since the method is not exactly the same, but the processes of reasoning used are the same, i.e. they reason from known data to unknown conclusions. The man in the laboratory assembles data, makes observations, and then reaches a conclusion which he did not know before. We in the court room are also in a laboratory; we have different instruments and different techniques, but we do exactly the same thing. We too want the answers to the questions that Dr. Fisher and Dr. Lilienthal outlined and want these answers in specific cases. We want to know the cause, the extent, the probable future of the medical condition, and the reasons for medical opinions. Where the tasks of the doctor and the lawyer differ is in the controlling conditions of the inquiry, and I think that a great deal of the misunderstanding between the two professions arises from failure to realize this difference. To the lawyer, the doctor's job looks pretty easy from the external point of view. We know how complicated and difficult the human body is. But what do you doctors have to do? You take the patient in to the hospital and put him to bed, and if you don't know what is the matter with him, just wait and maybe something will happen. Give him a pill; and if the pills don't work, get the surgeons to cut him open and let them see if they can find anything wrong. Take the patient and treat him as long as he is in the hospital, and then send him home cured, or if not cured, then send him to Dr. Fisher. Dr. Fisher will tell you, if he can, why the man died.

What are the external conditions in court? You may like or dislike them but they exist, and we are not talking now about reforms; we are talking about what we do and what we have to do. In the first place, we have the adversary system of litigation, where the plaintiff wants something that the defendant does not want to give him. There are two parties with opposing claims and opposing theories present in court, each one trying to convince the court, and by the court, of course, I mean the court and the jury, that he is right and the other side is wrong.

You don't have that formal outward battle in the medical world. You sometimes do in schools when you are medical students, and in arguments among yourselves as doctors, one advancing one theory, and another advancing another theory. But it is not part of the necessary organization of the inquiry. Another thing is, and this was suggested by Dr. Meyer, that we have only a limited time for decision. Furthermore, we have only a limited place for decision. But a more important point is that we are under the necessity of making a decision. Nobody can come into court asking for an answer to his claim and have the judge and jury say, "We are too busy to answer you" or, "We don't know what the answer is. Go on home." The court must decide, whether right or wrong, even though we know that we make many mistakes. The doctors do not have to decide.

A second basic difference between the professions is that we have a system of remedies which is quite different in theory from the medical system. The medical remedy is the direct remedy; if the man is sick, you cure him. But in court we must apply a substitutionary remedy. We cannot cure the plaintiff and the best we can do in most cases is to give money damages. There are some direct remedies, but the standard remedy in the law consists of money damages, an entirely indirect and substitutionary remedy.

Another one of our controlling conditions is that we must be bound by historic evidence, i.e., second-hand reports, not our own observations. When the doctor looks at the patient, he is looking right at the patient; and he accepts the evidence of his own senses, which he thereupon evaluates, and immediately acts upon it. We have to deal through a much more distant mechanism, whereby all of the evidence on which we act comes through a chain of observations, sometimes of one person, and sometimes of more.

We have, also, of course, the formal rules of law and procedure by which every one is bound. Those rules have many virtues; some have their vices; and many are complicated. Why are they complicated? Not because we are trying to make money by staying in court a long time, but because we live in a complicated society. I might just as well ask you to make medicine simple as you might ask me to make law simple.

There are some of these things, however, that can be improved. One point that often puzzles the doctors is the question why in the world the jury should decide technical medical questions. You have a medical question, and you put it up to the shoemaker, the candlestickmaker and the housekeeper; and they are supposed to decide the medical question. Well, why is that? Fundamentally, I think the reason is the basic political doctrine of the equality of man. Is your vote as good as mine? It is. Does the ignorant man who cannot read have the right to vote? Of course he has. And underlying all the absurdities of detail which that doctrine necessarily involves, fundamentally we believe it. But whether we believe it or not, we have the doctrine that the lay citizenry is the final arbiter of social questions.

There is a pretty good defense for this system. One good reason for it is that the doctors themselves do not agree. It often happens that Dr. A says that the plaintiff is permanently disabled, while Dr. B will say he is clearly a malingerer. Of course, that is not the usual case. The usual case is that Dr. A says he is 60 percent disabled, and Dr. B says he is 20 percent disabled. Who is going to say which doctor is right? The answer is that the public, represented by the lay jury, shall decide.

Another difficulty that the doctors have, has to do with cross-examination. I think there is more irritation caused by cross-examination by these bad-mannered lawyers whom I mentioned than by almost anything else. I do not believe it is understood generally what cross-examination is for. Cross-examination is not designed to annoy doctors. It is not designed to insult witnesses. It is designed to test the quality of the testimony being given. And it is a very effective means of doing so.

I am the last to defend bad manners under any circumstances, particularly in court. And I think that doctors should realize that cross-examination, if it does not impugn their veracity or their honesty, is really an opportunity for the doctors to back up and support their opinions. If they realized that, they would understand it and welcome it. If you have a shaky opinion, of course you do not want to be cross-examined, but if you really know what you are talking about, and can explain your opinion, then when you get through on cross-examination you and your opinion will be stronger than when you started.

On the mere surface level, there is a great deal of valid complaint by doctors about being brought down to court, sitting around and waiting, and told to go home; about doctors' having lawyers call them up to say, "Why aren't you down here" and by lawyers' setting cases for trial without consulting the doctors as to when they can be present to testify. All that complaint is thoroughly justified.

I think, however, that the situation is greatly improved over what it used to be. I tried a case only today in which there were two first-class doctors testifying. One of them had not been there at eleven-thirty when we had a short recess, but he was there at eleven thirty-seven. He went on the stand at about eleven thirty-seven and came out about eleven fifty-five. The other doctor came in in the meanwhile; he was put on at twelve-fifteen and left the court at about twelve-forty. Common sense and decency and courtesy, and the cooperation of every one involved, will cure complaints on this score.

Finally, if we must accept the adversary system, we do not have to accept it blindly, as being a trial of justice by exaggeration. What the Court wants is the truth, and what the jury wants is the truth. It seems to me that the greatest defect in our whole adversary system in America is the existence of the highly-paid expert who is not trusted by either side. Perhaps I should not put it in this way, but the expert for one side is sometimes regarded as a liar by the opposite side, and is often distrusted by both the judge and the jury.

Many doctors refuse to testify, because they know that they are going to be paid by one side, and that for that reason they will be suspected of bias, if not dishonesty. They think that there is a great deal of justification in holding similar views about the doctor for the opposing side.

I should like to see the rights of litigants preserved, to have just as many doctors as they please, just as many experts as they please; but I think that the court should have the right to appoint experts who are not hired to exaggerate for either side. How that can be done may not be too difficult. Whether it can be done under the present law is open to some question, but I do not think it is open to very much. I think such appointments would be entirely practicable. It seems to me that an immense amount of difficulty for lawyers, for clients, for doctors, would be removed if such a system could be established. And I hope that before long it will be.

I am sorry that my remarks have been so discursive. I will say, however, as the last man, you have heard the last from me unless somebody asks a question.

QUESTION AND ANSWER PERIOD

Mr. Due: I have here a number of questions which the experts are propounding to each other. But before we do that, I am going to ask several of the men in the audience—and I will start with Mr. O'Dunne, and Mr. Burke and Mr. Green, if you will go around and collect any questions that anybody has written, and present them to Mr. Stanley.

Q. Now, the first questions that I have here have been propounded by Dr. Fisher. And he has asked Dr. Lilienthal this question: Is there any substantial evidence to support the belief that a single or repeated trauma can cause cancer?

Dr. Lilienthal: No *single* trauma was ever responsible for the development of cancer. But I think that you can probably gather expert opinion—and the opinion you are going to hear from me is not expert—you can probably gather expert opinion to support either side. Nevertheless, if I may claim some expertness in selecting opinions from the so-called experts, I would like to answer that question: No; that it is possible, but the weight of the evidence is that a single trauma will certainly not. There are a few examples of repeated trauma, particularly in skin areas, associated with cancer. For example, the association of the development of cancer of the lip in pipe smokers, said to occur in a higher frequency than one might ordinarily expect with cancer of the lip.

Unfortunately, in biological observation quite an ordinary and casual relationship, which this may be, may be misleading. I think the answer to it at this stage of our knowledge is generally no.

Q. Mr. Due: Could I ask the doctor about that? Could it aggravate cancer?

Dr. Lilienthal: Mr. Due, you are getting me on the hook by accepting that part of my answer, which said "Yes, I think it could."

Mr. Due: Now, Dr. Fisher has a second question, propounded to Judge Niles.

Q. Dr. Fisher would like to know, Judge Niles, are there any judicial rules or Maryland precedents which enable the Court to discharge a defendant from responsibility in a death in which a therapeutic misadventure leads to fatal outcome of an otherwise probably non-fatal wound?

Judge Niles: Mr. Due, I might say that Dr. Fisher has made a "plant" there, because I tried that particular case, and he was the chief witness in it. It was a case that happened, I think about three years ago.

A boy down on Pratt Street got into an altercation with another boy and stabbed him. The stab was nothing but a minor abdominal wound. The boy was taken to the Johns Hopkins Hospital. He was sewed up. And everything was going along fine, except they thought he needed a transfusion. The transfusion did not seem to work. He got worse. They gave him another transfusion. The first transfusion I think was finished about three o'clock, and the next morning, about seven o'clock, they gave him another, and he still got worse. They first had typed his blood. And they started to look around and see if they could find anything that was wrong. And they found that the blood type was right, but the bottles got mixed up, and he was given the wrong blood. And the result of the accident was explained by Dr. Fisher in court. His kidneys clogged up. And the boy died. And the stabber was immediately indicted for murder.

Now, it was one of those borderline things. It was a question of what was the immediate cause of death. The stab was fatal, through a therapeutic misadventure.

It seems to me to be perfectly clear that this was a therapeutic misadventure, although I don't believe that term was used in court. I think that the term that was used was what was the proximate cause of death—was it the stabbing or was it the wrong blood? But more exactly, did an independent, intervening cause come in? I found that it did, and so I acquitted the boy of manslaughter, and found him guilty of assault with a deadly weapon.

Mr. Due: Now, I have some from Dr. Lilienthal to Dr. Fisher. This is more than a double-barreled question. It has five parts, apparently. It is this, Dr. Fisher.

Q. How reliable is the pathologist's evidence regarding cause of death in carbon monoxide asphyxia—let us take the first one, or do you want me to read them all? Do you have copies?

Dr. Fisher: I have copies, and I can simply take them all and answer them.

Q. Mr. Due: The second is exposure to heat, and the rest of them are drowning, sudden death, exposure to insecticides.

Dr. Fisher: Well, we are confronted with people who, in the case of carbon monoxide asphyxia and exposure to insecticides, have been poisoned. The pathologist's findings are, of course, as good as his chemical ability. In the case of carbon monoxide and most of the insecticides our science has advanced fairly far. In fact we are able to identify most of the particular chemicals which are capable of causing poisoning. In the case of carbon monoxide and insecticides we should be able by analysis to find the chemical and show that it was present in amount sufficient to cause the death. The occasional failure to reach this aim, of course, is where a patient survives long enough so that he throws off most of the poisonous element, but dies as a result of tissue damage he sustained before he threw off the poisonous substance. In that case we have to depend a little bit on the clinician, and how accurately he is able to evaluate the condition, and in addition to that, of course, also, the pathologist naturally would want to do a chemical analysis of the patient's blood while he was alive. In those two ways I feel we ought to come up with the diagnosis of poisoning nearly every time.

In the case of the other question here, exposure to heat and drowning, we are dealing with something that is more difficult to determine reliably. For example, in drowning we have chemical tests which will tell if a person shipped very much water. That is, if they take the water in, it goes into the blood and dilutes it, and we can determine that. The only catch is that nearly one third of the people who drown do not take in such a great amount of water because the conduit to the lungs becomes closed off (laryngeal spasm) and does not let in any water but they suffocate because they are under the water. Of course, in that case our chemical tests are not helpful, and we are restricted to inferential information. The patient was alive when he went into the water and we have no cause of death other than the fact that he was in the water. We would in that case become far less certain that he is dead because of drowning. So in two thirds of them we will have the particular evidence necessary to prove drowning while in the other third the decision that drowning occurred is primarily inferential. Much the same is true in exposure to heat, because certain patients have pathological findings that are clear-cut, and we can say, yes, these are findings that characterize heat stroke, or these are chemical changes in the blood that characterize heat exhaustion. In the other percentage of patients in whom the survival period, or the period between the onset of overheating and death is longer, the changes may not be clear-cut, and we are reduced completely to inferential information, to a clinical diagnosis, and to a positive lack of other causes of death.

Finally, in the one entitled sudden death, we are practically caught at sea. For example, the commonest cause of sudden death is heart disease. About two thirds of all of the non-violence deaths that come to the Medical Examiner's attention are deaths due to heart disease. And the catch is that of that group about a third will have something which the doctor at the autopsy or by microscopic examination, can say was no longer compatible with life and was surely the cause of death. It can be a ruptured heart, or a large area of heart muscle that has become completely dead, and caused the heart to stop. In the other two thirds of them the fatal changes are minutiae, that is there are abnormalities but the patient has survived with them and has had them for the last six months, or the last six days, or maybe for the last six years. Now if he could have survived for the last week with these anatomical abnormalities we are hard put to demonstrate just why the heart stopped at this particular minute. The answer is that the death is due to some physiological breakdown that we cannot show at the autopsy table. In other words it is a case of sudden strain which overloaded and stalled the already badly damaged pump. Our past experience with many similar cases where the same changes were accompanied by sudden death and we could find no other cause of death after complete study, leads us to the inference that the pathological findings, although compatible with life, are at the same time the cause of the death. Thus, in this large group of sudden deaths our diagnosis is inferential and we have no really accurate scientific way of saying that this is the immediate cause of death.

Q. Mr. Due: Dr. Lilienthal has asked this question of Judge Niles. It is; Most physicians dislike intensely being called as expert witnesses.

What changes would you suggest to improve this situation?

Judge Niles: Well, I think I have dealt largely with that already. It seems to me that the thing to do is to take the trouble not to become more annoying than necessary in dislocating the doctor's engagements. The fundamental change is to have a witness who is neutral, who is not going to exaggerate for one side or the other, and who, as the Court's own adviser, would tell exactly what he thinks is the truth of the matter.

Q. Now, I should like to counter that question with one to Dr. Lilienthal, and it is this: Would you object to cross-examination on your opinion, and in the second place, are you one of those who do not want to go into court?

Dr. Lilienthal: I think the trouble with answering Judge Niles' question is that it is a little bit double edged. I do not object to going into court. I would like to amplify that. Now, have you finished your question?

Q. Judge Niles: I have not, really. It is this: would you object to cross-examination on your opinion if the cross-examination were confined to its accuracy and probability, and you were protected against any suggestion of either incompetence or dishonesty?

And I think that question may be put to Dr. Meyer, too.

Dr. Lilienthal: I think unquestionably the answer is no. I don't know why I say no, but I would like to tell you of an experience I had some years ago, when I was called one afternoon by the City Solicitor's Office, who told me of an accident in which an elderly man and his somewhat younger wife were discovered in a small apartment, with all the stopcocks on the gas jets open, and they were both dead. It transpired that the man left an appreciable estate, and the point in issue was whether this estate would go to his wife's beneficiaries or legatees, if he had pre-deceased her, but if she pre-deceased him, the money I understood would go to the School Board. They told me the story, and then asked me if I would be willing to make any judgment. I said that I did not believe it was possible to say which of the two had died first. And then he broke it to me by saying, "Would you come down to court tomorrow and make a statement?" And so, having said it, I was caught, and I said yes, I would.

And I have never gone through a more delightful experience. The judge was most courteous. After I had gone through a somewhat embarrassing performance of establishing myself as an expert he asked me if I would tell the Court why I felt this way. The reason that it had come up was that another so-called expert like myself had made rather neat conjectures concluding that the man had died first; as clearly as I was able to, I told him why I thought it was impossible to say. At the close of this testimony, the judge leaned over to me, and in the most gracious way thanked me very kindly for having given this helpful testimony in a very clear way that was most convincing, and that if all testimony were like that, they would have no difficulty at all. I went home, and told my wife that there is nothing to this court business, that these are intelligent people, and all you have to do is say just what you think. And she accepted it quietly. But the next morning, while we were having breakfast, I noticed she was laughing while reading the newspaper which she turned over to me. What I read was that an expert from Johns Hopkins stated that it was impossible to tell which person had died first and that Judge So-and-so had awarded the estate to the wife's family.

And in that long-winded way, Judge Niles, I would like to answer the question you have asked. The answer is no, because the qualifications with which you have surrounded that statement would make the experience just as pleasant as the one I just described.

Judge Niles: Would you call that an unqualified answer?

Q. Mr. Due: Judge Niles, do you want to

ask that same question of Dr. Meyer, did you say?

Judge Niles: Yes, I would like to know what he has to say.

Dr. Meyer: The question is, would I object to cross-examination under the conditions set out in the question. This raises the issue, I think, what I like to do with my professional time as a psychiatrist. It is a matter of personal preference and interest. My interest is in therapy or treatment of illness. To me there is a marked difference between an interview with a patient as an assistant or friend of the court and a therapeutic interview. Where a court decision is in the offing the patient feels, even in a psychiatric interview, that he is on trial. There is less therapy than disposition in what brings the patient and psychiatrist together, and they both know it. I think I would find it rather frustrating work from the point of view of my personal psychiatric interests. However, if a panel of psychiatrists was established and one could count on only an occasional task of this sort, I would be willing to do it. I think this willingness would be based more on a sense of citizenship than anything else.

Q. Mr. Due: I imagine the question is academic as far as Dr. Fisher is concerned, because his duties require him to go to court. But if you care to say anything about it, doctor, I am sure we would like to hear from you.

Dr. Fisher: Well, with regard to the last question, whether or not I would be glad to testify, particularly as a neutral expert, obviously I would. It is the duty of the Medical Examiner to record the facts and let the chips fall where they may. It is true that occasionally a case gets far enough along that it is being heard in the superior court, and the Medical Examiner's testimony puts the kibosh on the "state's case." If we have information helpful to the defendant we do not hesitate to offer it; to that extent we are neutral experts.

But what I would like to comment on is the first part of this question—what changes might meet the situation.

Judge Niles has stated two very succinctly. And there is a third that I think we as physicians need to comprehend. That is the different objectives of medicine and the law. As a physician dealing with a patient we are interested purely and only in determining truth—the correct diagnosis—and if wrong the first time we can change our diagnosis and treatment until the truth is found. The courts on the contrary must make their final diagnosis and prescribe their treatment in one examination of the patient. They need, therefore, to hear all evidence in support of each possible diagnosis before they make their decision. There are many of my students coming into their later years at the Medical School who have the feeling that a court is a place, the hallowed halls of justice, where justice must be done in some ethereal way. What they have not learned is that the court is a place to settle arguments, that it is the civilized way of settling things that used to be settled by clubs in the back yard. And, of course, clubs in the back yard end up in a court of law. The point that I want to make is that the court is a place where an argument between the State and an individual, or between two individuals, shall be settled according to certain rules. These rules allow each side to put forth his best arguments. If the doctor thinks of it in these terms, then he realizes that even though he be to some extent partisan, he is there to present one side of an argument which the attorney who procured him has a duty to present.

Now, that is not an excuse for the doctor to extend or exaggerate the facts. But if the doctors remember that they are in court because there is a legal argument between two groups and that it is their duty as citizens to give the Court the benefit of their knowledge in order to support such legal argument, then I think the doctor, once he is sure he won't be abused in court, will better understand why there is cross-examination, and he will be more willing to come to court. An understanding of this difference in the viewpoint of the doctor and the lawyer is fundamental and I think a better realization of it will be very beneficial in relieving the situation that we now face, the difficulty in getting experts to come to court.

Q. MR. DUE: I have two more questions from Dr. Meyer, addressed to Judge Niles. And the first one is: Rapid and final settlement of litigation seems to be beneficial to people suffering neurotic reactions following trauma. Would you comment on the legal implications of this observation?

JUDGE NILES: I have thought of that question, and I am not sure that I can answer it satisfactorily. It would seem to me that what Dr. Meyer is asking is this, assuming that there is the phenomenon—and I believe it to be true—that when a case is settled the patient gets well, or gets better rapidly: is that something that the law should disregard or should take into account? You all know pain and suffering is one of the elements for which the law provides the substitutionary remedy of money. In other words, if a man's leg is broken and it hurts, the law cannot unbreak the leg, but the law can give damages for the pain, the law can give damages for the pain that he has suffered up to the time of trial, and for that which will probably be suffered after the trial.

Now, it seems to me that if there is true mental pain, characterized heretofore under the term that Dr. Meyer does not like, fracture neurosis, if that really causes suffering, then that should be compensated for in the same way as physical pain occasioned by the broken leg. And if it is going to get well when the patient wins his case, then it seems to me that should fall into exactly the same category as the lack of pain which follows a medical cure.

I hope I have given some answer to that question.

Q. MR. DUE: Now, the second question to you, Judge Niles, from Dr. Meyer is this: Recent studies have tended to show that certain people are "accident prone." In some cases there is a positive, though unconscious, wish for self-injury due to neurotic conflict antedating the accident. How would the law view a psychiatrist's report that an accident might have occurred for such a reason?

JUDGE NILES: Well, I think the theory of the law is quite clear that liability to pay damages is conditioned upon the fault of the defendant. If the fault is really a pre-existing cause resulting in self-injury, then the law would say no damages.

There is perhaps a borderline there that I have not really thought through, and that is this: If a man has abnormally brittle bones, then that is not blamed on the patient, but it is blamed on the man who broke them. Now, if the man has an abnormal tendency towards self-injury or self-injury results from this abnormality, which can be proved, then it might be argued that the injury was self-inflicted.

There you are getting into the realms where we lawyers are apt to get into trouble. How are we going to prove tendency to self-injury? How are we going to prove that the accident caused the injury itself? If we can get a definite answer that this accident was caused by a pre-existing disease and not by the injury, we are clear. And if it is a mixed-up question, then we are as mixed up as the doctors.

MR. DUE: Well, now, those are all of the questions which the experts have propounded to each other. Mr. Stanley has separated these other questions into the respective persons, and I am going to ask him to deliver each of these to the respective experts and let them read them and answer them, because sometimes you take those things better through the eye than the ear. And we will start out with Judge Niles and go on across.

Q. JUDGE NILES: This question is addressed to me, and it is as follows—Wouldn't the Court-appointed "medical expert" remove, almost in its entirety, from the jury the question of which expert is right, that is, in cases where there is an honest difference on medical opinion?

The answer would seem to me to be that the Court-appointed expert would have the advantage over the partisan experts. That is exactly what it is intended to do. I do not believe it would remove the question from the jury.

I think, further, that if the partisan experts, or the parties' experts, which is a pleasanter name, knew that the Court had appointed an expert, in many cases I think that all three of them would get together and come in with a unanimous report.

But I do not wish to conceal the fact that I think the appointment of a Court expert would make the Court expert more and more important than the parties experts. And that is just why it would be a good thing.

MR. DUE: Dr. Lilienthal, do you want to take one?

Q. DR. LILIENTHAL: Yes, Mr. Due. The question is, "Assuming that a medical witness testifies that a given pathological condition might *possibly* have resulted from a given trauma, what approach can the lawyer take to show the relative improbability of the result?"

I have a feeling this is giving away secrets.

The only approach I can give you is the one that doctors usually assume under circumstances such as Judge Niles pointed out, and that is when they argue among themselves. It is very easy for the first-year intern to make a decision, because he has seen a case. As years pass, however, the decision becomes a little more difficult. This is probably an area where, if you are willing to accept statistical probabilities, and they have been qualified so that the limits of confidence are well known—this is an area where the physician, who is operating statistically and without conclusive evidence, may at the time he assesses the evidence say that the chances are ten-to-one that this is the case, and if that ten-to-one looks like a reasonable operating chance, he will proceed on that basis.

So that the answer to this is there is no answer, and I think all that the lawyer can do is to attempt to define and to get the doctor to define what he believes the statistical chance is. From there on I have no doubt that he can use whatever statistical rate comes out in the way that suits him best.

MR. DUE: Dr. Fisher, will you take one?

Q. DR. FISHER: Yes. I have one here that is actually two. It reads: It seems that Dr. Fisher bases his medical findings to fit legal results. And then there is a question mark. Is that a fair conclusion? Is he a doctor, lawyer, or judge, or all three? Is he truly neutral?

Now, obviously, there are several questions here which certainly are stimulating. As a matter of fact, I would say it is not a fair conclusion that the medical findings are based to fit legal results. I believe it is a medical problem as to which of the three categories that I used for descriptive purposes here tonight a given situation lies in. In other words, I believe it is a medical problem as to whether an injury contributed significantly to a death due to preexisting disease. Certainly there is the legal problem involved, too, but if the doctor, the pathologist, does not attempt to answer the question, he is of no value to the court in reaching a decision. In the same way, the doctor who is evaluating a pulmonary embolism, a clot following an injury, must for the purpose of having an opinion that is useful, decide whether it is a natural consequence of the injury or an unrelated disease. This is a medical matter and I do not believe that is being a judge. I think it is a matter of trying to evaluate, trying to analyze the medical situation in terms that will be useful and will be explained so as to make applicable the legal principles that govern the case.

The third one is the therapeutic misadventure. I am not attempting to deny that the pathologist, who is charged with the duty of being a Medical Examiner, is a little bit in the middle sometimes. But evidently since I am required by law, as a Medical Examiner, to submit all cases which in my opinion require any further investigation or action to the State's Attorney and there are a certain number of therapeutic misadventures which come to my desk, I must decide then which of these I will send on to the State's Attorney. As an example, there are cases in which unexpected complications occur and lead to, let us say an anesthetic death, and in which, to even a critical individual, it is fairly obvious that this is an accidental or an allergic response to anesthesia and no one contends that there is negligence involved. In such a case I might well not submit it to the State's Attorney. I exercise my judgment in such cases and that is the extent of what I am doing.

If that is what you refer to as being lawyer or judge, I can only reply that I am charged with this duty by law, in regard to the Medical Examiner cases and I assure you I lean most heavily upon those who are with me in the investigative end of the work and consult with the State's Attorney and the police investigators in case of any doubt.

Finally, I will answer that question, is he truly neutral? I think you are being neutral if you determine the facts, even though you determine them and state them in a way which is intelligible I hope, to the attorney or the court who must be concerned with it.

I think one can be just as neutral in stating them in those terms as one might be in stating them in complicated medical opinions, using words that cannot be found in an English dictionary. I am sure we must interpret the facts in terms that the attorney and the court and the jury can understand if they are to be helped by our work.

MR. DUE: Dr. Meyer, do you want to take a question?

Q. DR. MEYER: The question is: "Is it possible to assess with any real accuracy the causal connection between trauma and subsequent neurosis?"

I answer again, yes and no. No, if you are asked to do it at a particular time and predict what will happen, and you are limited to that. And yes, in certain cases, if you are doing therapy with the patient and have a chance to intervene in the situation of the neurosis as a therapist, and then have a chance to see what this intervention has produced in the neurotic situation, and what it will bring about. By and large, this is a hindsight establishment of a causal connection.

MR. DUE: Judge Niles, will you take as many of the remaining questions that you may care to answer at this time?

Q. JUDGE NILES: I think I can answer these rather briefly. The first one is very easy. It is, Will the talks be published for future reference? And the answer is, Yes, they will appear in the Medical Journal.

Q. Now, the next question has to do with that expert matter, which has a companion question. The question is, With all the admitted room for honest differences of medical opinion, why would the disinterested medical expert be considered the "last word" on a contested issue?

I do not think he would be considered the last word any more than disinterested witnesses are now considered the last word in fact matters, the ordinary fact matters.

For example, the policeman who visits the scene of the accident and gives evidence as to the positions of automobiles, debris, skid marks, and so on, is usually accepted as a very powerful and competent witness, but in the end, too, all of the witnesses are subjected to test, as was pointed out by Dr. Fisher.

I think the great virtue of the neutral witness would be that his opinion would be freed from the charge of bias, to which it is certainly now subject. And I think that the parties who win cases are those who present their cases with the most sincerity. And as to experts, the best experts are those who talk simply and give clear and understandable reasons. And I think the same thing would be true under a system whereby the court would appoint the expert, but that expert would not be subject to the question of having shaded his opinion to the interest of either himself or the man who paid him.

Q. Now, the next question is rather a difficult one to answer. It is this: To what extent can the attorney aid the physician in studying the patient, and vice versa, to what extent can the physician aid the attorney in his investigation of a claim or of a defense?

I cannot give a practical answer to the question, because of the infinity of variations on the facts. It would seem to me that there must be a real collaboration between the physician and the lawyer. The lawyer should explain to the physician exactly what it is that he wants to know, what he wants to prove, and to work with the physician to help him to bring out that point. And the ordinary virtues that are involved in fairness, in confidence, in a willingness to work, are the ones that will solve all those problems.

MR. DUE: Thank you, Judge Niles.

Q. Dr. Meyer, can you summarize yours?

DR. MEYER: Yes. There are three questions here, and I will be brief in answering them.

Q. The first one is, "What personality changes should be expected, if any, following a cardiac condition, and if so, why?"

The question is too broad to answer, and it would depend on what kind of cardiac condition it was, the severity of it, and so on.

Q. And here is another question. "Is there really such a thing as a 'post-traumatic syndrome' or is it a catch-all by a physician who cannot accurately diagnose?"

I think it is a catch-all.

Q. And the last one is: "Is not a hysterical manifestation wherein the patient is disabled, a disability in the same sense as organic disablement for as long as it exists?"

Yes, from the medical point of view, it is so. But there may be implications in terms of the legal situations that we have to think about. If all neurotic conditions are to be put on a par with physical disability in the eyes of the law, I think it opens up rather important areas that have not as yet been fully considered. I would like to see more emphasis on prevention and treatment of these syndromes rather than greater elaboration of a complex system of compensations.

Q. MR. DUE: Dr. Lilienthal, do you have any additional questions?

DR. LILIENTHAL: There are two very specific questions here, and I think I can answer them briefly.

Q. The first is, "What is your opinion of the plausibility of instantaneous diabetes following trauma?"

I think there are two points of interest here. One is that the course of diabetes can be measurably altered for the worse in accompaniment with stresses of both infection and emotional nature. That has been competently observed time and time again. Secondly, we are dealing with a disease which may exist for some time without the appearance of symptoms. It is only when routine examination discloses the presence of diabetes that its existence is established. Whether or not it existed before is conjectural and not subject to proof.

Q. The second question is: "Is arteriosclerosis a usual aftermath of diabetes?"

I think I can answer that very simply by saying that one of the accompanying processes of diabetes frequently is arteriosclerosis.

Q. And there is the final question, which I will break up into two parts.

The first part starts out with this: "Can't doctors agree"—and the answer to that is no. And the rest of the question reads on, "Can't doctors agree that asymptomatic arthritis or congenital conditions are not to be considered as part of a disability caused by trauma?"

I think that partial answers have been given this evening, in discussion of the question of how much handicap existed before the trauma and what was the nature of the trauma which aggravated it. I don't know the answer. I think that my answer to the first part of it, as I divided it, is perhaps the more valuable one, and that is that doctors often cannot agree.

Q. Mr. Due: Dr. Fisher, do you have any more questions?

Dr. Fisher: No, I do not.

Mr. Due: Well, that concludes the questions, ladies and gentlemen. I might say that I am merely the conduit through which the matter has been presented to you. And I want to thank the three doctors and Judge Niles for being here tonight.

REFERENCES RELATING TO "VIEWPOINT OF THE PSYCHIATRIST" BY DR. EUGENE E. MEYER, III

(See pages 312 to 315)

1. Catton, J., *Psychotherapy of Posttraumatic Neuroses: Lump-Sum Settlement.* Clinic of Dr. Joseph Catton. Medical Clinics of North America, May 1923.
2. Buzzard, E. F., *Traumatic Neurasthenia.* Lancet 2: 1285, 1923 (Dec. 15).
3. Fetterman, J., *Traumatic Neurosis.* J.A.M.A. 91: 315, 1928 (Aug. 4).
4. Bastin, C. H., *Traumatic Neurosis.* Canadian M.A.J. 22: 653, 1930.
5. Fetterman, J., *The Neuroses Associated with Trauma.* Industrial Med. 4: 4, 1935.
6. Kennedy, F., *Neuroses Following Accident.* Bull. N. Y. Acad. Med. 6: 1, 1930.
7. Barker, L. F., *The Present Status of So-Called "Traumatic Neuroses."* The Nation's Health 9: 12, 1927.
8. Ruesch, J. and Bowman, K. M., *Prolonged Post-Traumatic Syndromes Following Head Injury.* Am. J. Psychiat. 102: 145 1945

A STUDY ON THE RECIPROCAL RELATIONSHIP OF HYPERTENSION AND GASTRO-INTESTINAL BLEEDING

SAMUEL MORRISON, M.D.,* WILLIAM CARL EBELING, M.D.† and VAN B. BENNETT, M.D.‡

Introduction

After observing several hypertensive patients through episodes of manifest hemorrhage from the gastrointestinal tract, one of us (S. M.) was of the opinion that hypertensive patients may bleed into their stomachs or duodenums repeatedly without the existence of local gastrointestinal lesions, in a manner somewhat analogous to epistaxis. There was little in the literature to substantiate this opinion. References to hematemesis or other forms of manifest gastrointestinal hemorrhage have appeared rarely in writings about hypertension, and then hemorrhage has been mentioned only as an uncommon occurrence.

References to hypertension have appeared occasionally in writings about peptic ulcer. In 1924 Eyster and Middleton, considering the effects of hemorrhage and transfusion on the blood pressure, concluded that these phenomena within 1% of the body weight in man, result in only transitory alterations of blood pressure[1]. In 1935 Wilbur and Ochsner reported a study done in 1929. They had found simultaneously a 2% incidence of peptic ulcer in 200 hypertensive patients, and 3.2% incidence of peptic ulcer in the total clinic population[2]. However, they did not make clear their criteria for hypertension. In 1939 Jones reported a phase of "reactive hyper-

---

* University of Maryland, School of Medicine, Baltimore 1, Maryland.

† Massachusetts General Hospital, Boston 14, Massachusetts.

‡ Little-Griffin Hospital, Valdosta, Georgia.

tension" in patients with bleeding peptic ulcer, noted particularly within six to 24 hours after hemorrhage[3].

In 1941 McFarlane, studying the mechanism of hemostasis, concluded that given normal coagulative elements of the blood, the primary mechanism of hemostasis is the contraction of the severed blood vessel, with the formation of a clot in the surrounding tissues, not within the lumen of the vessel[4]. In 1942 and again in 1944 Rafsky and Weingarten, studying the effects of age and hypertension on patients with bleeding peptic ulcers, concluded that hypertension did not increase the severity of bleeding in peptic ulcer and that the gross mortality of patients with hypertension increased because of the occurrence of complicating diseases[5]. They used 140/90 mm. Hg as the upper limit of normal blood pressure.

In 1950 Sullens and coworkers reported no deaths in patients with upper gastrointestinal hemorrhage and blood pressures above 150 mm. Hg, a mortality of 8.4% in those with pressures between 100 and 150 mm. Hg systolic, and a mortality of 37% in those with systolic pressures of 90 mm. Hg or lower at the time of hospitalization[6]. In the same year Ivy and coworkers stated that although it has been suggested that hypertension predisposes to hemorrhage from peptic ulcer, the data which bear on this question are meager. These writers claimed that the presence of a high blood pressure (over 150/90 mm. Hg) in a patient during a bleeding episode would indicate that the patient had not lost much blood, or it might indicate a "reactive hypertension" (a compensatory vasoconstriction) in a patient with an otherwise normal blood pressure. On the other hand, a normal blood pressure might indicate considerable blood loss in a patient with an otherwise high blood pressure, or a relatively small blood loss in a normotensive person whose cardiovascular system has compensated for the decreased blood volume by vasoconstriction and tachycardia[7].

The purpose of this paper is to present further observations on the incidence and effect of hypertension in patients with gastrointestinal hemorrhage. So that there would be no misinterpretation of the presence or absence of hemorrhage, these observations were restricted to unselected hospitalized patients with hematemesis regardless of cause. The total hospital population from which these cases were drawn is unknown, but the dates of admission extend back about 25 years through the history of a busy general hospital.

The criteria for hypertension were considered as carefully as were the criteria for hemorrhage. Goldring and Chasis in 1944 stated that hypertension is the unidentified physiologic disturbance (or disturbances) which leads ultimately to elevation of the diastolic and systolic blood pressures, anatomic changes in the vascular tree, and functional impairment of the involved tissues[8]. In 1949 Ranges pointed out that the hypertensive disease probably starts years before the blood pressure readings reach significantly high levels, and that cardiac enlargement, retinal changes and electrocardiographic abnormalities may be present prior to the blood pressure remaining elevated. He made clear that many people with hypertension may live a long and symptom-free life[9].

Opinions about what is the normal blood pressure vary considerably. In 1938 Allen wrote that the normal blood pressure of the total population for different ages and sexes is unknown[10]. It is still unknown but most clinics use 150/90 mm. Hg or higher pressures as indicative of hypertension.

Adequate statistics on the incidence of hypertension in the general population are wanting in many details. Numerous large series are available but the criteria and the conditions of observation are so variable that detailed comparisons cannot be made. It is well established that the incidence of hypertension increase with advancing age, being very low before the age of 20 years and increasing to 60% or more in elderly persons. The influence of sex, race, heredity and arteriosclerosis complicates the problem even more.

In 1948 Smith attempted to summarize the data in the literature and to establish the incidence of hypertension in the general population. He concluded that the overall incidence for adults was about 25%[11]. In 1951 Perera stated that he and his group had never observed the incidence to be greater than 6% in any series of patients[12]. Because of these incongruities, it is impossible to decide whether the incidence of hypertension in any group of cases with hematemesis is increased or decreased.

MATERIAL

The hospital records of four hundred patients with hematemesis were studied for the presence of hypertension. These records were analysed for each patient's age, sex, race, blood pressure level and diagnosis. The patients with blood pressures consistently 150/90 mm. Hg or higher were considered to have been hypertensive. Their charts were studied further in order to establish the diagnosis of hypertension and to rule out both the blood pressure raising effects of therapy and the phase of "reactive hypertension" after hemorrhage as the causes of elevated blood pressures.

The charts of patients with peptic ulcers were studied further to determine how the diagnoses were established: by signs and symptoms alone, by roentgenograms, or by direct visualization of the ulcers at laparotomy or autopsy. The charts of all patients with fatal outcomes were studied further to determine the causes and the modes of death.

RESULTS

The age range of the 400 patients was from six years to 82 years. Three hundred six (76.50%) were males, and 94 (23.50%) were females. Three hundred thirty-seven patients (84.25%) were white, and 63 (15.75%) were colored.

The causes of hematemesis were varied. Three hundred and two patients (75.50%) had peptic ulcers. Of these, 163 patients (40.75% of 400) had diagnoses established by roentgen examination, laparotomy, or autopsy. One hundred thirty-nine other patients (34.75% of 400) had diagnoses on the basis of signs and symptoms alone, often with normal roentgenographic findings.

The one hundred sixty-three cases with demonstrated ulcers were studied to learn the sites of involvement. One hundred thirty-one patients (80.38% of 163) had duodenal ulcers. Twenty-six patients (15.96% of 163) had gastric ulcers, five had marginal ulcers and one had a combination of gastric and duodenal ulcers.

Ninety-eight patients (24.50% of 400) had causes of hematemesis other than ulcer. Twenty-nine of these (7.25% of 400) had esophageal varicies. Nineteen patients had no obvious disease. Fourteen had gastritis, eight had hiatus hernias and four had carcinoma of the stomach. Five had duodenal diverticula as possible causes of hematemesis, and three others had prolapsed gastric mucosa. Three had advanced renal disease, and two had disseminated lupus erythematosus. Two had typhoid fever. The remaining nine of the 98 patients had miscellaneous, different causes of hematemesis.

Hypertension was present in 38 patients of the 400 for an incidence of 9.50%. All 38 had diastolic pressures of 90 mm. Hg or more. All but one had systolic levels of 150 mm. Hg or higher. Twenty-four of the hypertensives had peptic ulcers and comprised 7.94% of the 302 ulcer patients. Fourteen patients had other causes of hematemesis. Table I gives the distributions of these 38 patients according to age, race, and sex.

Death occurred in 52 of the 400 patients with hematemesis for a mortality of 13.00%. Of the 362 normotensive patients, 44 died for a mortality of 12.15%. Of the 38 hypertensive patients, eight died for a mortality of 21.05% as outlined in table II.

Each of the ulcer and non-ulcer groups was divided into two groups: all patients 50 years of age and older were considered separately from those under 50 years of age. Although this division created much smaller groups, it separated the effects of hypertension from those of advanced age.

When the 302 patients with peptic ulcers were studied, there were 24 with hypertension and 278 with normotension. The patients below 50 years of age with hypertension had a mortality of 11.11% while those with normotension had a mortality of 3.97%. The patients 50 years of age and older with hypertension had a mortality of 20.00% while those with normotension had a mortality of 15.68%. These results are shown in table III.

Table I

Characteristics of 38 Hypertensive Patients

AGE, YEARS	24 WITH ULCER	14 WITHOUT ULCER
31–40	2	—
41–50	8	3
51–60	7	2
61–70	6	6
71–80	1	2
81–90	—	1
Male	15	10
Female	9	4
White	21	14
Negroid	3	—

When the 98 non-ulcer patients were studied, there were 14 with hypertension and 84 with normotension. The patients below 50 years of age with hypertension had a mortality of 0% while those with normotension had a mortality of 26.53%. The patients 50 years of age and older with hypertension had a mortality of 36.36%, while those with normotension had a mortality of 22.85%. These results are shown in Table IV.

Eight hypertensive patients died. The only one of these below the age of 50 years was a woman 39 years of age who died from peritonitis after perforation of an ulcer. A man 67 years of age died of a similar incident. Two patients, a man 51 years of age and a woman 55 years of age, died from exsanguination. A man 69 years of age had carcinoma of the stomach. A man 50 years of age had a cerebrovascular accident, a woman 65 years of age had congestive failure, and a man 72 years of age died of chronic renal disease with uremia.

Table II

400 Patients with Hematemesis

	38 WITH HYPERTENSION		362 WITH NORMOTENSION	
	Under 50 Yrs.	50 Yrs. & Older	Under 50 Yrs.	50 Yrs. & Older
Number	12	26	225	137
Deaths	1	7	20	24
Mortality	8.33%	26.92%	8.88%	17.51%
	Overall mortality 21.05%		Overall mortality 12.15%	

Table III

302 Patients With Peptic Ulcer

	24 WITH HYPERTENSION		278 WITH NORMOTENSION	
	Under 50 Yrs.	50 Yrs. & Older	Under 50 Yrs.	50 Yrs. & Older
Number	9	15	176	102
Deaths	1	3	7	16
Mortality	11.11%	20.00%	3.97%	15.68%
	Overall mortality 16.66%		Overall mortality 8.27%	

Table IV

98 Non-ulcer Patients

	14 WITH HYPERTENSION		84 WITH NORMOTENSION	
	Under 50 Yrs.	50 Yrs. & Older	Under 50 Yrs.	50 Yrs. & Older
Number	3	11	49	35
Deaths	—	4	13	8
Mortality	0%	36.36%	26.53%	22.85%
	Overall mortality 28.57%		Overall mortality 25.00%	

These last four patients were not considered clinically to have ulcers, so they are from the non-ulcer group. That leaves only four patients in the hypertensive group who died of peptic ulcer per se. Two of these four died of perforation and two died of exsanguination. Therefore, the incidence of fatal exsanguination in these 24 patients with peptic ulcers and hypertension was 8.33%.

Twenty-three patients with peptic ulcers and normotension died. Fourteen died of exsanguination; of these 14, four were complicated by coronary or cardiac factors and in one of these four, a curious reactive hypertension was recorded; three patients died of perforation and six of postoperative complications. In six others, carcinoma, uremia and other serious conditions were dominant factors, leaving only four patients in whom exsanguination alone was clearly the cause of death (17.39%).

Twenty-one patients with non-ulcer causes of hematemesis and normotension died. Sixteen of these died from bleeding esophageal varices with or without liver failure. One died from lymphoma and one from carcinoma of the colon. One died from a ruptured aneurysm of the hepatic artery, another from typhoid fever, and still another from acute adrenal cortical failure.

CONCLUSIONS

The incidence of hypertension in 400 unselected patients with hematemesis has been shown to be 9.50%. In 302 of these patients with hematemesis from peptic ulcers, the incidence has been shown to be 7.94%. Applying the same criteria for hypertension, in 1942 Rafsky and Weingarten found an incidence of 10.29% in 408 ulcer patients[5a].

The incidence of hypertension in the general adult population is unknown but probably between 6% and 25%, less likely up to 40%. Therefore it is impossible to conclude that there is anything unusual about the incidence of hypertension in patients with hematemesis.

The effect of hypertension on mortality is difficult to evaluate. If one considers the cases with hematemesis from all causes, but predominantly from ulcers, it is obvious that the older patients fare worse when they are hypertensive. Apparently their poor outcome is on the basis of associated disease processes, not increased hemorrhage.

If one considers only the cases with hematemesis from peptic ulcer, it seems that the major effect of hypertension on mortality is in the younger patients where there was a rise in mortality of about 7% (3.97% to 11.11%) in our small group of patients. This increment is similar to the 6.5% increase found by Rafsky and Weingarten[5b]. In the older patients with hypertension there was a rise in mortality of about 4% (15.68% to 20.00%).

Exanguination was the mode of death in 8.33% of the patients with peptic ulcer and hypertension. It was the cause of death in 17.39% of the patients with peptic ulcer and normotension. Rafsky and Weingarten found exsanguination to have occurred in 5.9% of their hypertensive patients and 4.1% of their normotensive patients with peptic ulcer[5a].

SUMMARY

1. The incidence of hypertension (150/90 mm. Hg or higher) in 400 unselected patients with hematemesis was 9.50%.
2. The incidence of hypertension in 302 patients with hematemesis from peptic ulcer was 7.94%.
3. The incidence of hypertension in a comparable group from the general population is unknown, but probably under 25%.
4. The mortality of patients with hematemesis from peptic ulcers seemed to be increased by the co-existence of hypertension.
5. This effect was more evident in younger patients than it was in older patients.
6. The increased mortality was not the result of exsanguination, for the incidence of exsanguination was less in the hypertensive group than in the normotensive group.

BIBLIOGRAPHY

1. Eyster, J. H. A., and W. S. Middleton, Cardiovascular reactions to hemorrhage and transfusion in man, Am. J. Physiol. 68: 581, 1924.
2. Wilbur, D. L., and H. C. Ochsner, Association of polycythemia vera and peptic ulcer, Ann. Int. Med. 8: 1667, 1935.
3. Jones, F. A., Hematemesis and melena: Observations on the use of continuous drip transfusions, Brit. Med. J. 1: 915, 1939.
4. McFarlane, R. G., Mechanism of hemostasis, Quart. J. Med. 10: 1, 1941.
5. Rafsky, H. A., and M. Weingarten, (a) Bleeding peptic ulcer, J. Am. Med. Ass. 118: 5, 1942; and (b) The effect of hypertension on the prognosis of bleeding peptic ulcer, Rev. Gastroent. 11: 93, 1944.
6. Sullens, W. E., F. Steigmann, and K. A. Meyer, Surgical considerations in upper gastrointestinal hemorrhage, quoted by Ivy, A. C., M. I. Grossman, and W. H. Bachrach: Peptic Ulcer, The Blakiston Company, Philadelphia, 1950.
7. Ivy, A. C., M. I. Grossman, and W. H. Bachrach, Peptic Ulcer, The Blakiston Company, Philadelphia, 1950.
8. Goldring, W., and H. Chasis, Hypertension and Hypertensive Disease, The Commonwealth Fund, New York, 1944.
9. Ranges, H. A., Benign aspects of hypertensive disease, Med. Clin. N. Amer. 33: 611, (May) 1949.
10. Allen, E. V., in Musser, J. H., Internal Medicine, Third Edition, Lea and Febiger Company, Philadelphia, 1938.
11. Smith, H. W., Hypertensive and urologic disease, Am. J. Med. 4: 724, 1948.
12. Perera, G. A., The natural history of hypertensive vascular disease, in Hypertension—A Symposium, edited by E. T. Bell, University of Minnesota Press, Minneapolis, 1951.

* * * * *

FORMER MEDICAL OFFICERS SURVEYED

A.M.A. News Notes, Vol. 2, No. 4

In analyzing 467 questionnaires returned by former armed forces medical officers, the Council on National Emergency Medical Service has extracted pertinent data on percentage of time spent in treatment of military personnel and their dependents, staffing conditions and the number of physicians willing to remain in service.

The survey of former army, navy and air force physicians shows:

(1) *Percentage of time:* Between 44% and 54% of total overseas time was spent in treatment of military personnel and between 39% and 53% of total domestic time. Treatment of dependents took between 19% and 28% of overseas time and between 25% and 44% of domestic time.

(2) *Staffing conditions:* Overstaffing—136 replies—ranged from 15% to 44%. Understaffing—79 replies—ranged from 15% to 28%. Adequate—227 replies—ranged from 42% to 58%.

(3) *Willing to stay in service:* 214 replied yes; 236 no.

The Council will continue to send out questionnaires to physicians as they return to civilian life.

* * * * *

PROFESSIONAL EDUCATION EXPENSE DEDUCTIONS FROM TAXABLE INCOME

The AMA Washington Letter, No. 15

H.R. 4393 (Davis, D.—Ga.). Although present tax laws permit taxable income deductions for ordinary and necessary expenses in trade or business, there is no express provision in the law to permit professional persons to deduct the cost of additional education. This bill would permit deduction of reasonable costs of additional education, if for the purpose of carrying on a profession, improving professional qualifications or increasing profession remuneration. *To Ways and Means Committee.*

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

Dr. F. Ford Loker, who is on the surgical staff at the University of Maryland, was guest speaker at the March meeting of the Allegany-Garrett County Medical Society.

Dr. Loker discussed the "Use of Some of the Newer Anti-coagulants in the Treatment of Thromboembolic Disease."

Local Physicians Speak Before Civil Defense Group

Dr. Oliver R. Roth, Dr. Ralph Ballin and Dr. Louis Brings, all of Cumberland, spoke recently before the Nurse's Division meetings for Allegany County Civil Defense. Dr. Roth's lecture was "Communicable Diseases," Dr. Ballin spoke on "The Treatment of Korean Chest Wounds" and Dr. Brings spoke on "Maternity and Care of the Newborn."

Personals

Dr. W. Royce Hodges, local obstetrician and gynecologist, attended the four-day meeting of the American College of Surgeons, in Boston.

Dr. Irving Baumgartner, of Oakland, Maryland was elected a member of the board of directors of the American Academy of General Practice, during the organization's fifth annual meeting March 23 to 26 in St. Louis. Dr. Baumgartner will serve for three years.

Dr. H. Thomas Robinson, Cumberland pediatrician, has received orders to report for active duty the second week in May at Gunter Air Base, Montgomery, Alabama.

A member of the USAF Reserve Corps, Dr. Robinson has been practicing here for five years. He was graduated from the Medical School of Johns Hopkins Hospital, Baltimore, in 1944. Born in Cumberland, he is the son of Mrs. Ann Robinson and the late Dr. Howard T. Robinson, Sr.

CARROLL COUNTY MEDICAL SOCIETY

WILBUR H. FOARD, M.D.

Journal Representative

The Carroll County Medical Society had its regular March meeting at Hoffman Inn in Westminster but not until a delicious 3 inch steak dinner was downed by 22 members and guest speaker.

Dr. David Will, Associate in Surgery at the University Hospital, was guest speaker and spoke on the Complications of Peptic Ulcers and the Recommended Surgical Treatment of these Complications.

Dr. Thomas Vestal, of the Henryton State Hospital, was voted into the Medical Society which brings the membership of the Carroll County Medical Society to 37. Dr. Vestal was formally from North Carolina.

Dr. Julius Chepko, of Westminster, who broke his leg this winter when he slipped on the ice, was present at the meeting and we are glad to report he is gradually recovering from the accident.

PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

JOHN M. WARREN, M.D.

Journal Representative

The new year began for us with special emphasis on two things: first of all, our outgoing President, Dr. Samuel Sugar, urged a membership drive to bring in new men who had recently moved to this territory; secondly, Dr. Warren has organized a special Speakers' Bureau under the leadership of Dr. Richard Bauer of Hyattsville.

The membership drive is still in its infancy. Its methods are simplicity itself. Our members make it their business to contact newcomers in their immediate areas. Those missed by this plan are located and canvassed by mail through the use of names and addresses furnished by the county licensing authority—in our case the clerk of the court. More will be forthcoming on this later.

The Speakers' Bureau is composed of nine men especially chosen for their speaking ability and knowledge of the community. They have as their goal the promotion of better understanding between physicians and the community which they serve. P.T.A.'s, civic associations, school and church groups are only a few of the outlets so far that have been contacted by this committee.

In January our group became affiliated with the local Blue Cross Insurance Plan and most all of our members now have the hospitalization coverage.

Our Legislative Committee has been active on two state bills and our work here has made concerted medical thinking a potent political force.

The Speakers Bureau of the Prince George's County Medical Society, under the leadership of Chairman Richard Bauer, has arranged for a 15-minute weekly radio program over station WNAV every Wednesday at 1:30 P.M. This station (1430 AM) has transmitters in Annapolis and studios in Laurel, Maryland. Dr. Warren, our President, acted as lead-off man for the first quarter-hour program held April 8. The show, which is called "Community Medicine Today," will deal with topics of wide general interest to the lay public. Future shows will include discussions on heart disease, polio, and the new wonder drugs.

In addition to the radio program, members of the Speakers' Bureau have already been before area P.T.A. meetings. So far, Drs. Sam Sugar, Dick Bauer, and Henry Wolfe have done their stint in the name of the society.

The Society's Legislative Committee, headed by Chairman Waldo B. Moyers who is also a delegate to Med. Chi., won their fight to pull the county hospital (Prince George's General) out from under political domination. In the closing days of the State Legislature, an act to set up the hospital under a 9-man Board of Directors passed successfully after the Society paid a hurried visit to Annapolis to stump the measure.

Our Society's scientific programs have been easier to come by since so many physician specialists from the Washington area have become associate members. We have recently been addressed by Dr. Louis Bachrach, D. C. Urologist; Dr. Alfred Suraci, D. C. Plastic Surgeon; Dr. William Stecher, Silver Spring, Radiologist; Dr. James Feffer and Dr. Moe Weis, T. B. men from Glen Dale Sanitarium; and Dr. Lloyd Hughes from College Park, area Anesthesiologist.

On June 11, Dr. Fred Musser is arranging the annual Society Golf Tournament at the Prince George's Golf and Country Club. Last year Dr. Lloyd Hughes won the gold cup. Since then, many of our members have been risking pneumonia by practicing in the rain to upset Lloyd this year. There will be a dinner in the evening climaxing the afternoon's athletics.

WASHINGTON COUNTY MEDICAL SOCIETY

OMAR D. SPRECHER, Jr., M.D.

Journal Representative

The second regular quarterly meeting of the Washington County Medical Society was held in the Maryland Room, of the Alexander Hotel.

Dr. Harry C. Hull, Clinical Professor of Surgery, University of Maryland, School of Medicine, Baltimore, Maryland, spoke on "Hematemesis and Melena."

A new administrator has been appointed at the Washington County Hospital. He is John A. Schaffer of Reading, Pennsylvania, who holds a Master of Hospital Administration Degree from Northwestern University and for the past three and one half years has been administrative assistant of the Reading Hospital. He is a member of the American College of Hospital Administrators and the Hospital Association of Pennsylvania.

* * * * *

CONGRESS ASKED TO APPROVE STUDY OF U. S.-STATE RELATIONSHIPS

The AMA Washington Letter, No. 14

VA Changes. Dr. Albert M. Snell of Palo Alto, Calif., is new chairman of the Veterans Administration's Council of Chief Consultants, succeeding Dr. Ralph M. Tovell, who will remain on the Council. Reappointed to the Council are Drs. Harold G. Scheie (as vice-chairman), John N. Robinson, Bernard J. Pisani, and Norton Canfield. A new member of VA's Special Medical Advisory Group is Dr. John Raaf. The Council advises the Chief Medical Director, while the Group advises the Administrator.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

A Few of the Recent Publications by Faculty Members

Abeshouse, B. S., and Ruben, M. E., Prostatic venography, Modern Medicine 21: 148, 151, January 15, 1953.

Andrus, E. C., The thyroid and the circulation, Circulation 7: 437–444, March 1953.

Bagley, Charles, Jr., and Smith, G. W., Sphenoid ridge meningiomas, Bull School Med., Univ. Maryland 37: 103–114, July 1952.

Baptisti, Arthur, Jr., Cervical pregnancy, Obst. & Gynec. 1: 353–358, March 1953.

Baxter, M. D., and Shackelford, R. T., Hernia of the lung: method of repair with tantalum mesh, A. M. A., Arch. Surg. 65: 856–861, December 1952.

Bennet, E. T., Endometriosis in the older age group, Am. J. Obst. & Gynec. 65: 100–108, January 1953.

Berman, E. F., A plastic prosthesis for resected esophagus, A. M. A., Arch. Surg. 65: 916–919, December 1952.

Blair, Emil, and Yeager, G. H., Regitine®, clinical observations on a new adrenolytic and sympatholytic drug, Bull. School Med., Univ. Maryland 38: 20–31, January 1953.

Bradley, J. E., Antibiotics—that ounce of prevention, (editorial) Bull. School Med., Univ. Maryland 38: 1, January 1953.

Brady, Leo, Late results with the interposition operation, Am. J. Obst. & Gynec. 65: 400–406, February 1953.

Chesney, A. M., Four decades of medical progress, Bull. Johns Hopkins Hosp. 92: 171–179, February 1953.

Conn, J. H., Hypnotherapy of chronic war neuroses with a discussion of the value of abreaction, regression, and revivication, J. Clin. & Exper. Hypnosis 1: 29–43, January 1953.

Conn, J. H., Hypnotic relaxation and analysis in "Therapy through hypnosis," New York, The Citadel Press, 1952.

Crosby, R. M. N., Treatment of post-pneumoencephalographic headache with β-pyridyl carbinol tartrate (roniacol tartrate), Am. J. M. Sc. 225: 61–66, January 1953.

Crosby, R. M. N., Wagner, J. A., and Nichols, Pomeroy, Jr., Intradural lipoma of the spinal cord, J. Neurosurg. 10: 81–86, January 1953.

Dammann, J. F., Jr., Berthrong, Morgan, and Bing, R. J., Reverse ductus, Bull. Johns Hopkins Hosp. 92: 128–150, February 1953.

Diehl, W. K., Antibiotics in gynecology (editorial), Bull. School Med., Univ. Maryland 37: 133, July 1952.

Douglass, L. H., Gilbert, R. A., Kaltreider, D. F., and McNally, H. B., The evaluation of the Willet clamp scalp traction by means of the tokodynamometer and comments on the use of the clamp, Am. J. Obst. & Gynec. 65: 40–44, January 1953.

Douglass, L. H., Morrison, J. H., and Oster, Robert, Cerebral dysrhythmia and acute toxemia of pregnancy, Obst. & Gynec. 1: 287–288, March 1953.

Edwards, C. R., and Jennings, E. R., Peptic ulcer, a five year review, Ann. Surg. 137: 329–333, March 1953.

Feldman, Maurice, The incidence of the coexistence of gastric and duodenal ulceration, Gastroenterology 23: 304–308, February 1953.

Feldman, Maurice, Multiple primary carcinomas of the small intestine: a review of the literature, Am. J. Digest. Dis. 20: 1–3, January 1953.

Feldman, Maurice, and Myers, Philip, The diagnostic evaluation of erect positioning in cholecystography, Radiology 60: 222–225, February 1953.

Fisher, A. M., and McKusick, V. A., Bacteroides infections: clinical, bacteriological and therapeutic features of fourteen cases, Am. J. M. Sc. 225: 253–273, March 1953.

Fox, S. L., Clinical applications of pharmacologic principles and rational therapy in otolaryngology, Bull. School Med., Univ. Maryland 37: 115–121, July 1952.

Futcher, P. H., and Sauvé, G., Detection of mild diabetes mellitus by feeding glucose to induce glycosuria, Diabetes 2: 31–36, January–February 1953.

Go Lu, Brahen, L. S., and Krantz, J. C., Jr., Anesthesia. XXXVIII: Quantitative measurement of mucosal irritation of volatile anesthetics, Anesthesiology 14: 143–152, March 1953.

Goldstein, A. E., Rubin, S. W., Sachs, Louis, and Weinberg, Tobias, Formation of an artificial urinary bladder in the human, Bull. School Med., Univ. Maryland 38: 2–19, January 1953.

Goplerud, Jane, and Eastman, N. J., Compound presentation: a survey of 65 cases, Obst. & Gynec. 1: 59–66, January 1953.

Green, T. W., Conley, C. L., Ashburn, L. L., and Peters, H. R., Splenectomy for myeloid metaplasia of the spleen, New England J. Med. 248: 211–219, February 5, 1953.

Green, T. W., Conley, C. L., and Berthrong, Morgan, The liver in sickle cell anemia, Bull. Johns Hopkins Hosp. 92: 99–125, February 1953.

Grishman, Arthur, Scherlis, Leonard, and Lasser, R. P., Spatial vectorcardiography, Am. J. Med. 14: 184–200, February 1953.

Grob, David, and Harvey, A. M., The effects and treatment of nerve gas poisoning, Am. J. Med. 14: 52–63, January 1953.

Gundry, R. K., Psychotic or delinquent? J. Am. M. Women's A. 7: 403–408, November 1952.

Hayleck, M. L., Common feeding problems in children, J. Am. M. Women's A. 7: 409–411, November 1952.

Howard, J. E., Hopkins, T. R., and Connor, T. B., On certain physiologic responses to intravenous injection of calcium salts into normal, hyperparathyroid and hypoparathyroid persons, J. Clin. Endocrinol. & Metabol. 13: 1–19, January 1953.

Huebner, R. J., Risser, J. A., Bell, J. A., Beeman, E. A., Beigelman, P. M., and Strong, J. C., Epidemic pleurodynia in Texas, New England J. Med. 248: 267–274, February 12, 1953.

Jacobson, S. M., and Greene, R. C., Morphology of healed tuberculous meningitis following streptomycin therapy, Am. J. Med. 14: 132–136, January 1953.

Jewett, H. J., Urinary tract obstruction in childhood, Modern Medicine 21: 112–114, January 15, 1953.

Jewett, H. J., and Harris, A. P., Scrotal ureter: report of a case, J. Urol. 69: 184–187, January 1953.

Johns, T. N. P., Dissecting aneurysm of the abdominal aorta, Ann. Surg. 137: 232–235, February 1953.

Johns, T. N. P., Williams, G. R., and Blalock, Alfred, The anatomy of pulmonary stenosis and atresia with comments on surgical therapy, Surgery 33: 161–172, February 1953.

Johnson, R. W., Jr., Hillman, J. W., and Southwick, W. O., The importance of direct surgical attack upon lesions of the vertebral bodies, particularly in Pott's disease, J. Bone & Joint Surg. 35–A: 17–25, 114, January 1953.

Jones, H. W., Jr., and Jones, G. E. S., Double uterus as an etiological factor in repeated abortion: indications for surgical repair, Am. J. Obst. & Gynec. 65: 325–339, February 1953.

Kanner, Leo, Child psychiatry, Mental Deficiency, Am. J. Psychiat. 109: 511–514, January 1953.

Koontz, A. R., Geriatric surgery—the surgery of neglect, Geriatrics 8: 93–98, February 1953.

Koontz, A. R., Modern management of inguinal hernia, GP 7: 43–55, January 1953.

Krantz, J. C., Jr., Musser, R. D., and Knapp, N. J., Sugar alcohols. XXIX. Sorbitan polyoxyethylene fatty acid esters and polyoxyethylene monostearate and respiration of kidney, Proc. Soc. Exper. Biol. & Med. 81: 640–642, December 1952.

Kress, M. B., A report on the use of carbarsone in pulmonary tuberculosis, Dis. Chest 23: 309–312, March 1953.

Langworthy, O. R., Neuropathology, endocrinology, and biochemistry, Am. J. Psychiat. 109–493–496, January 1953.

Levin, M. B., and Gwynn, B. A., The treatment of ulcerative colitis, Am. J. Digest. Dis. 20: 29–31, February 1953.

Marriott, H. J. L., In praise of leisure, Bull. School Med., Univ. Maryland 37: 129–132, July 1952.

McCrumb, F. R., Jr., Mercier, S., Robic, J., Bouillat, M., Smadel, J. E., Woodward, T. E., and Goodner, K., Chloramphenicol and terramycin in the treatment of pneumonic plague, Am. J. Med. 14: 284–293, March 1953.

McKusick, V. A., Boeck's sarcoid of the stomach with comments on the etiology of regional enteritis, Gastroenterology 23: 103–113, January 1953.

Miller, J. M., Ginsberg, Milton, and Scarborough, C. P., Successful construction of an artificial antethoracic esophagus, J. Thoracic Surg. 25: 107–110, January 1953.

Miller, J. M., Surmonte, J. A., and Long, P. H., The intrabronchial use of streptokinase and streptodornase in the treatment of slowly resolving pneumonia, Dis. Chest 23: 149–153, February 1953.

Milnor, W. R., Talbot, S. A., McKeever, W. P., Marye, R. B., and Newman, E. V., A photoelectric ear densitometer for continuously recording the arterial concentration of T-1824 in the dye-dilution method, Circulation Research 1: 117–121, March 1953.

Newell, H. W., and Schultz, K. L., Brief therapy for acute anxiety in a five-year-old girl, Am. J. Orthopsychiat. 23: 186–203, January 1953.

Novak, Emil, Hormone-producing ovarian tumors, Obst. & Gynec. 1: 3–14, January 1953.

Pearce, M. L., McKeever, W. P., Dow, Philip, and Newman, E. V., The influence of injection site upon form of dye-dilution curves, Circulation Research 1: 112–116, March 1953.

Peirce, E. C., 2nd., Temporary hemiplegia from cerebral injection of diodrast during catheter aortography, Circulation 7: 385–392, March 1953.

Peirce, E. C., 2nd., and Southworth, J. L., Pump circuit for experimental intracardiac surgery of the left heart, A. M. A., Arch. Surg. 66: 218–225, February 1953.

Randolph, M. E., and Eareckson, V. O., The Von Graefe and keratome incision in cataract extractions, Am. J. Ophth. 36: 350–353, March 1953.

Rich, A. R., Voisin, G. A., and Bang, F. B., Electron microscopic studies on the alteration of collagen fibrils in the arthus phenomenon, Bull. Johns Hopkins Hosp. 92: 222–243, March 1953.

Richter, C. P., Symposium: light from animal experimentation on human heredity. I. Domestication of the Norway rat and its implication for the study of genetics in man, Am. J. Human Genet. 4: 273–285, December 1952.

Rosen, Harold, Hypnodiagnostic and hypnotherapeutic fantasy-evocation and acting-out techniques, J. Clin. & Exper. Hypnosis 1: 54–66, January 1953.

Scarborough, W. R., Davis, F. W., Jr., Baker, B. M., Jr., Mason, R. E., Singewald, M. L., Lore, S. A., and Fox, L. M., A ballistocardiographic study of 369 apparently normal persons, Am. Heart J. 45: 161–189, February 1953.

Scott, Eleanor, Brachial palsy following gynecologic surgery, J. Am. M. Women's A. 7: 415–416, November 1952.

Scott, Eleanor, and Harrison, E. P. H., Jr., Induction of labor by rupture of the membranes in private practice, J. Am. M. Women's A. 7: 399–402, November 1952.

Scott, H. W., Jr., Cantrell, J. R., and Bunce, P. L., The principle of aortic compression in the management of massive hemorrhage from the renal pedicle after nephrectomy, J. Urol. 69: 26–31, January 1953.

Shulman, L. E., Schoenrich, E. H., and Harvey, A. M., Allergic reactions to therapeutic agents: treatment with adrenocorticotropic hormone (ACTH) or cortisone, Bull. Johns Hopkins Hosp. 92: 196–209, March 1953.

Shulman, L. E., Schoenrich, E. H., and Harvey, A. M., Effects of ACTH and cortisone on sarcoid, Modern Medicine 21: 81–82, January 15, 1953.

Smith, E. P., Toulson, W. H., and Rever, W. B., A simple method of evacuating blood clots from the urinary bladder with streptokinase-streptodornase, Surg., Gynec. & Obst. 96: 171–174, February 1953.

Smith, G. W., and Miller, J. M., The relief of tic douloureux with stilbamidine, Ann. Int. Med. 38: 335–338, February 1953.

Smith, G. W., Mosberg, W. H., Jr., Manganiello, L. O. J., and Choudens, J. A. A. de, Torulosis of the central nervous system in the laboratory animal, Bull. School Med., Univ. Maryland 38: 32–41, January 1953.

Southworth, J. A., Peirce, E. C., 2nd., Tyson, Thomas, and Bowman, R. L., Diaphragm pump for artificial circulation, Tyson-Bowman pump, A. M. A., Arch. Surg. 66: 53–59, January 1953.

Taback, Matthew, and Williams, Huntington, Statistics in a health department medical care plan, Pub. Health Rep. 68: 157–166, February 1953.

Taussig, H. B., and Bauersfeld, R. S., Follow-up studies on the first 1,000 patients operated on for pulmonary stenosis or atresia (results up to March, 1952), Ann. Int. Med. 38: 1–8, January 1953.

Thomas, C. B., The heritage of hypertension, Modern Medicine 21: 133–134, January 15, 1953.

Tran-Dinh-De, and Anderson, G. W., Hyaline-like membranes associated with diseases of the newborn lungs: a review of the literature, Obst. & Gynec. Surv. 8: 1–44, February 1953.

Trimble, I. R., and Morrison, Samuel, Autonomic approach to pain control, Modern Medicine 21: 129–130, January 15, 1953.

Waters, Z. J., McCullough, Kendrick, and Thomas, N. R., Lingual thyroid, A. M. A., Arch. Otolaryng. 57: 60–78, January 1953.

Wilkins, Lawson, Teaching clinic: the diagnosis of sexual abnormalities, J. Clin. Endocrinol. & Metabol. 13: 369–374, March 1953.

Woodward, T. E., The chloramphenicol problem, Modern Medicine 21: 67–71, January 1, 1953.

Health Department

BALTIMORE CITY HEALTH DEPARTMENT

Permanent Black Ink Needed On Birth And Death Certificates

On April 10, 1953 the Commissioner of Health of Baltimore sent a letter to each physician in the city requesting care in using permanent black ink in making out all birth and death certificates.

A copy of the letter was sent on April 15, 1953 to each Hospital Superintendent, Medical Record Librarian and Funeral Director in the city.

The text of the letter, which is self-explanatory, is as follows:

Dear Doctor:

It has come to my attention that some of the birth and death certificates registered with our Bureau of Vital Records are written with inks too light to enable the City Health Department to make legible photostatic copies of them.

As you probably know, the Health Department discontinued making typewritten transcripts of birth and death certificates about two years ago. To improve our service to the public, the photographic reproduction of vital records by photostat was initiated. This innovation has led to a more efficient and expeditious program for handling the continually increasing volume of requests for certified copies of such vital records.

In those cases where records have been written with a light ink, we have been unable to produce photostatic copies which would be acceptable to any agency that might require proof of the facts contained in birth and death certificates.

Because of the above, I am writing to urge you to adopt the following suggestions in preparing original birth and death certificates that you hereafter file with the Baltimore City Health Department:

1. USE A TYPEWRITER WITH A FRESH BLACK RIBBON WHEREVER POSSIBLE, EXCEPT FOR THE SIGNATURE.
2. WHERE THE USE OF A TYPEWRITER IS IMPRACTICABLE, AND FOR THE SIGNATURE:
   a. USE PERMANENT BLACK OR BLUE-BLACK INK. PERMANENT BLACK INK IS PREFERRED.
   b. PLEASE WRITE PLAINLY AND LEGIBLY.
   c. DO NOT USE A BALL POINT PEN. THE INKS USED IN SUCH PENS HAVE BEEN FOUND TO BE NON-PERMANENT, AND WITH TIME LEAVE ONLY FAINT PRESSURE LINES.

I cannot emphasize too strongly that the permanent preservation of birth and death certificates is of vital importance to the persons named on the records, and to their beneficiaries. If the certified photostatic copies issued are to be satisfactory reproductions of our vital records, the responsibility for properly preparing the original certificates lies with the persons required by statute to register such records with the Health Department.

Your watchful care and assistance in this very important matter will be deeply appreciated.

Sincerely yours,

Huntington Williams, M.D.

Commissioner of Health

GAMMA GLOBULIN DISTRIBUTION

Because of the tremendous amount of public interest about gamma globulin in the prophylaxis of poliomyelitis and the consequent numerous inquiries which physicians are receiving, the Maryland State Plan for Gamma Globulin Distribution is printed in full below. This plan was presented at the annual meeting of the Faculty in Baltimore on April 29 by Dr. Perry F. Prather, Deputy Director of the State Health Department, following a general discussion of the present status of active and passive immunizations against poliomyelitis.

MARYLAND STATE DEPARTMENT OF HEALTH

Plan for Gamma Globulin Distribution

Based on Office of Defense Mobilization Directive dated April 15, 1953 and recommendations State Polio Planning Committee—March 31, 1953. Approved by Maryland State Board of Health April 17, 1953

I. Background

In the summers of 1951 and 1952 Hammon and associates conducted a series of carefully controlled studies in Utah, Texas, and Iowa-Nebraska,—54,772 children between the ages of 1 and 11 years were inoculated, half with gamma globulin and half with gelatin. These children resided in epidemic areas at the time of the tests. Hammon's group appear to demonstrate significant protection against paralytic poliomyelitis *from the second through the fifth week after injection* in the Iowa-Nebraska experience. In addition, children who developed paralytic poliomyelitis within the first week after gamma globulin injection were shown to have had modification of the illness, so that paralysis was less severe than in a comparable group receiving gelatin.

On the basis of this evidence, the National Foundation for Infantile Paralysis cooperating with the American Red Cross is making available the entire limited supply of gamma globulin for prophylactic use this summer. The Office of Defense Mobilization, acting on the advice of the allocation panel of the National Research Council, has announced that the nation's supply of gamma globulin will be distributed through State and Territorial Health Officers. The O.D.M. directive dated April 15, 1953, outlines the formula which will be used in determining allocation of supplies to individual States for measles and hepatitis as well as polio prevention. In addition several criteria are recommended for efficient and effective use of the very limited supply.

The annual meeting of the Maryland State Polio Planning Committee was held early this year (March 31, 1953) to consider the problem and to develop the plan for gamma globulin distribution. This plan was presented to the State Board of Health and approved April 17, 1953.

II. Limitations of Effectiveness

The proper place of gamma globulin in prophylaxis against paralytic poliomyelitis is yet to be worked out. It has not been shown whether or not gamma globulin interferes with the development of active immunity. The period of protection is brief and subsequent exposure may still result in paralytic polio. It has been estimated that for every 1000 injections of gamma globulin under ideal conditions approximately one case of paralytic poliomyelitis may be prevented. This number is further reduced when one considers that only 30% of paralytic cases ultimately have residual paralysis of a handicapping degree.

III. Limitation of Supply

Gamma globulin is in extremely short supply. There will be only about one million doses of gamma globulin available from now to September for some 46 million children and adolescents in the more polio-susceptible age groups. It is clear that strict control must be exercised in conserving the supply so that the greatest benefit will be achieved.

IV. Criteria for Use

1. *Non-epidemic* use*

Gamma globulin will be available for administration only to household contacts of clinically diagnosed cases who are less than 18 years of age and to pregnant women in the household. (Note: This age group would include all school age children, and, according to Maryland Statistics since 1916, 95% of all polio cases—the overwhelming majority—have been less than 18 years of age.) A "household contact" is any person who lives in the same dwelling unit and who is known to have been in such association with an infected person as to have been presumably exposed to infection.

A "clinically diagnosed case" of poliomyelitis is based on the following: Poliomyelitis should be considered when one sees a patient with an acute febrile illness with signs of meningeal irritation. Headache, vomiting, and sore throat are common symptoms. The most frequent sign is stiffness of the back. Spasm of hamstring muscles and stiffness of the neck may sometimes be found. Generalized asthenia and head drop may be part of this picture. The diagnosis is almost certain if in addition flaccid weakness of muscle groups is found. Poliomyelitis must frequently be differentiated from bacterial meningitis and other forms of virus meningo-encephalitis such as mumps, lymphocytic chorea-meningitis, and meningismus occurring with infections such as bacillary dysentery and tick bite fever. It is also necessary to distinguish between true muscle weakness and pseudo-paralysis due to painful infection or an injury to an extremity.

---

* The existence of an "epidemic" will be determined by the local Health Officer and the State Director of Health. When required, for allocation purposes, further investigation by trained epidemiological personnel will be undertaken by the Office of Defense Mobilization.

It is often not necessary to perform a lumbar puncture in order to make a probable diagnosis of poliomyelitis. If the cerebrospinal fluid is examined, the more usual findings are a moderate increase in cells with a slight increase in protein and normal concentration of sugar. These findings are not pathognomonic of poliomyelitis. Therefore the diagnosis of non-paralytic poliomyelitis is a tentative one.

When there is doubt as to the diagnosis, consultation should be sought.

2. *Epidemic* use*

In the event of a recognized epidemic, mass community prophylaxis of the high-risk age groups will be carried out by the local Health Officer within the limits of the supply of gamma globulin on hand or available by special allocation from the Office of Defense Mobilization.

V. ADMINISTRATION OF GAMMA GLOBULIN

Time: Gamma globulin should be given to the household contacts *as soon as possible* after diagnosis of a primary case. Under no circumstances should it be given later than three weeks after the onset of the symptoms of a primary case.

Site: It is recommended that gamma globulin be given deep intramuscularly in the upper outer quadrant of the *right* buttock. (It is suggested that the right buttock always be used uniformly for statistical reasons.)

Dosage: On the basis of 0.14 cc. per pound, the following simplified dosage table has been worked out:

Below 6 mos.— 2 cc.
15–20 lbs.— 3 cc.
21–29 lbs.— 4 cc.
30–35 lbs.— 5 cc.
36–42 lbs.— 6 cc.
43–50 lbs.— 7 cc.
51–57 lbs.— 8 cc.
58–64 lbs.— 9 cc.
65–75 lbs.—10 cc.
Over 75 lbs. give 1 cc. per year of age up to 15 cc.
(Children 16–18 yrs.—15 cc.)
Pregnant women—20 cc.

Amount to Issue: Since the vials contain 10 cc. issue the fewest vials which cover the calculated need to the nearest half vial (5 cc.).

Examples: Calculated amount 14 cc.—issue 1 vial.
Calculated amount 15 or 16 cc.—issue 2 vials.

VI. LOCAL SOURCE OF SUPPLY AND REQUIRED INFORMATION

Supplies will be located in the local Health Department. Only licensed physicians may request gamma globulin. In order to obtain gamma globulin for prophylaxis, physicians are required to furnish to the local Health Department the name, address, date of onset, and satisfactory verification of the patient's diagnosis (see Section IV), as well as the names, ages, and weights of household contacts to be inoculated. Requisition blanks will be supplied for this purpose. Where possible additional epidemiological investigation will be done by the local Health Officer to obtain data for statistical analysis of the effectiveness of gamma globulin prophylaxis.

R. H. Riley

Director

---

* See footnote on page 340.

STATE OF MARYLAND DEPARTMENT OF HEALTH

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, May 1–28, 1953

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCAL	MUMPS	POLIOMYELITIS, PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS
																		Influenza and pneumonia
Total, 4 weeks																		
Local areas																		
Baltimore County	56	—	40	1	43	—	54	—	—	77	—	1	1	25	—	18	—	2
Anne Arundel	18	—	4	7	10	—	21	—	—	6	—	—	1	3	—	3	—	2
Howard	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—
Harford	5	—	44	—	7	—	9	—	—	2	—	—	—	—	—	—	m-3	1
Carroll	5	—	4	—	7	—	9	1	—	2	—	—	—	—	—	2	—	—
Frederick	—	—	—	1	—	—	—	—	—	—	—	—	—	1	—	2	—	—
Washington	3	—	—	—	5	—	5	—	—	1	—	—	—	7	—	1	—	—
Allegany	2	—	1	3	43	—	—	—	—	—	—	—	—	10	—	1	—	2
Garrett	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—
Montgomery	22	—	24	3	30	—	41	—	—	8	—	2	—	14	—	2	—	1
Pr. George's	9	—	11	3	31	—	31	1	—	13	—	—	—	14	—	—	e-1	1
Calvert	5	—	—	1	1	—	1	—	—	2	—	—	—	—	—	—	—	—
Charles	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	—	—
Saint Mary's	—	—	—	4	4	—	3	—	1	—	—	—	—	—	—	—	—	—
Cecil	1	—	—	—	—	—	1	—	—	—	—	—	—	2	—	2	—	—
Kent	4	—	16	—	1	—	6	—	—	7	—	—	—	1	—	—	—	1
Queen Anne's	—	—	2	—	—	—	—	—	—	2	—	—	—	1	—	—	—	—
Caroline	5	1	2	—	—	—	3	—	—	—	—	—	—	—	—	3	—	—
Talbot	—	—	—	—	—	—	2	—	—	—	—	—	—	—	—	2	—	—
Dorchester	2	—	—	—	—	—	6	—	—	—	—	—	—	1	—	5	—	—
Wicomico	—	—	1	—	1	—	—	—	—	—	—	—	—	6	—	15	—	1
Worcester	1	—	—	—	1	—	4	—	—	—	—	—	—	—	1	—	—	1
Somerset	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—
Total Counties	138	1	149	23	184	0	196	3	1	120	0	3	2	88	1	58	—	12
Baltimore City	176	0	191	8	237	0	271	0	1	271	0	0	6	102	7	562	—	15
State																		
May 1–28, 1953	314	1	340	31	421	0	467	3	2	391	0	3	8	190	8	620	—	27
Same period 1952	412	1	126	20	758	9	94	1	0	117	1	1	24	234	12	542	—	42
5-year median	465	5	114	—	840	6	242	1	5	110	2	4	40	238	63	521	—	42
Cumulative totals																		
State																		
Year 1953 to date	2486	8	1289	182	949	45	1358	6	2	1967	8	5	80	988	63	3137	—	431
Same period 1952	2244	6	667	120	8463	57	638	7	0	694	8	10	90	1136	64	2599	—	373
5-year median	2593	43	413	—	3120	50	1152	2	5	749	9	22	309	1143	422	2709	—	361

e = meningo-encephalitis.

m = malaria reported by Aberdeen Proving Grounds, origin outside the U. S., home residence not given.

BLUE CROSS AND BLUE SHIELD

THE BLUE SHIELD PHILOSOPHY

R. H. DABNEY*

You, as a physician, are a part of Blue Shield—so, naturally, you are concerned about it. You are a part of it because Blue Shield is sponsored by the medical profession. The State Insurance Department considers this backing of Blue Shield by a majority of Maryland physicians to be most significant and necessary. So you are a part of Blue Shield because of action taken by your medical society whether or not you are a Participating Physician.

Therefore, we can all benefit by reviewing the "Blue Shield Philosophy" from time to time. Functionally, Blue Shield is like an insurance company, but philosophically, it is not. Blue Shield was organized for 'service' not profit. But only the medical profession can make 'service' benefits available to the public, Blue Shield being used as a medium for this purpose.

Blue Shield does much to ease the paralyzing effects of large medical bills through the 'service' clause, whereby no additional payment is required from eligible subscribers when they are treated by Participating Doctors. The public is invariably enthusiastic about 'service' Plans. The trend is strongly toward the service Plan philosophy. Indeed, the 'service' philosophy—namely, furnishing complete or virtually complete medical service instead of dollars—is the unique and most popular feature of Blue Shield.

The public is the "consumer" of medical care and the "consumer" must be protected if the voluntary Plans are to serve their purpose as the chief bulwark against compulsory health insurance. Blue Shield, then is *your* contribution toward supplying a non-profit medical care Plan to help pay or pay medical costs. It is *your* contribution to furnish an important component in the voluntary health insurance field—as opposed to the compulsory political type. So your support is essential.

You can give your support by explaining Blue Shield to your patients, friends, and business contacts. Your secretary needs to know about it, too. Filling out forms promptly and completely is important. The more complete information you furnish, the better can the Medical Department process your cases.

On the other hand, Blue Shield has an inescapable obligation to the public and the medical profession. It must accomplish three things:

1. Provide the subscriber with broad enough protection to remove his worries in respect to the cost of medical care.
2. Provide the doctor with a reasonable income, even though he should be largely dependent upon a "Blue Shield practice."
3. Keep the subscription charges within the cost-of-living range of the average individual and family.

Through the understanding cooperation of the Medical profession, Blue Shield *is* playing its part in making modern medical care accessible to more and more people in Maryland. We are sure that the cooperation of the doctors of Maryland will continue to come freely and in full measure in the future.

---

* Executive Director, Maryland Hospital Service, Inc. and Maryland Medical Service, Inc.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. CHARLES H. WILLIAMS, *Auxiliary Editor*

ADDRESS OF THE INCOMING PRESIDENT

MRS. JOHN G. BALL

Members and Guests of the Woman's Auxiliary,

I greet you as a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland.

Mrs. John G. Ball

First of all, I thank you for the confidence you have placed in me and I will endeavor to work faithfully with your officers and committee chairmen to uphold the high ideals and follow the program of the Woman's Auxiliary of the American Medical Association.

Our work will be successful only if each individual member does her part. No job is too big, no effort is too small, to count. If any of you doctor's wives are not members of the Woman's Auxiliary, please consider it your privilege, as well as your responsibility, to join your county auxiliary, to become a member-at-large or to help organize your county. We, in Maryland, have a big job to do and need many helpers.

The component auxiliaries have many special projects, chief of which are the Nurse Recruitment and Nursing Scholarship Programs. Civil Defense or Civil Preparedness must be stressed this year. Public Relations is a program we all share, for in our day to day contacts, we are living public relations for the medical profession. So it is with most of our Auxiliary work. Every doctor's wife is doing it. We surely do a better job when we all band together to pool our resources and information. An informed Auxiliary member is medicine's as well as your own husband's best helper.

In the few years that our Auxiliary has been organized, we have achieved some worthwhile goals. Someone has said, each year we should build a step so that those who follow us can climb a little higher and more safely. In the coming year with the help of all of you, we shall be able to do just this.

Good luck to you all and thank you.

REPORT TO AMERICAN MEDICAL ASSOCIATION WOMAN'S AUXILIARY

MRS. CHARLES H. WILLIAMS*

The Woman's Auxiliary to the Medical and Chirurgical Faculty has had an interesting and constructive year.

Our group joined the Ballot Battalion, a nonpartisan group in Baltimore in an effort to "Get

---

* Immediate Past President.

Out the Vote." Baby sitting centers were organized in churches and doctors' offices throughout the city and were manned by our members. One of our counties took care of the telephone calls for their entire area for all information and service during election day. Recently we were notified that our work helped the Battalion win a major award in the 1952 National Register and Vote Competition Contest sponsored by the American Heritage Foundation.

The booklet "Winning Ways with Patients" was placed in many business and high schools throughout the state to help train and inform medical secretaries and receptionists.

Four of our counties sponsored health exhibits at fairs. Medical literature, "A Doctor for You," "Your Doctor for a Friend," etc. was given out to thousands. An electric quiz box especially prepared for us by the Maryland Society for Medical Research was a large attraction. One very successful exhibit featured movies obtained from the American Medical Association. Student nurses were kept busy taking blood pressures gratis.

We have worked on Civil Defense, Cancer drives and Medical Research programs. A resolution for a day to honor the physician successfully passed our legislature and most county physicians were honored by radio shows, newspaper publicity, theater parties, dinners and dances.

Future Nurses' Clubs were organized in many schools. We cooperated with hospital superintendents, nursing associations and "Careers for Nursing" by supplying them with films and exchanging speakers. All of our counties now have nursing scholarships and one county had to cut theirs in half this year because the award was won by twin sisters. High schools were visited, teas planned and hospital tours conducted. A nurse recruitment film is being made of our nursing schools at a cost of twenty-five hundred dollars. The fund for this was made up from contributions. This film will be shown throughout Maryland free of charge to enlighten students on various hospital facilities. A reception was held to honor the practicing nurses of our state and was well attended. Cakes were sent to some nursing homes, a TV set purchased for another and an award is now given to a nurse graduating with distinguished all-around efficiency. On Florence Nightingale's birthday (May 12) we plan our first "Future Nurses" Convention. This is a "scientific session" modeled after an AMA meeting with films, a hospital superintendent, doctors, nurses, and student nurses as speakers. Already several hundred high school students have made reservations to attend.

We supported our medical schools by contributing to the American Medical Education Fund. An old tradition of a social event at our annual medical convention has been revived this year by the Auxiliary.

* * * * *

DEFENSE DEPARTMENT'S DOCTOR DRAFT BILL INTRODUCED

The AMA Washington Letter, No. 14

A bill extending the Doctor Draft to July 1, 1955 was introduced in the Senate by Chairman Leverett Saltonstall of Senate Armed Services Committee and Senator Lester Hunt. The Defense Department, which had drawn up the measure, informed Congress that the administration felt that extension "is considered to be the only means" by which the armed forces can get enough doctors to meet needs for the next two years.

Major provisions in the bill include: (a) four present priority groups continued, (b) service credit given co-belligerents of World War II, (c) 24 months retained as required period of service, (d) maximum induction age kept at 51, (e) men who have served less than a year since June 25, 1950, liable for recall, but those who have served over a year not liable during 2-year life of this act, and (f) aliens made subject to service.

Physicians would be commissioned in grades "commensurate with . . . professional education, experience or ability." (It makes no mention of the $100 a month equalization pay which is part of the Career Compensation Act.)

Ancillary News

DENTAL SECTION

BALTIMORE CITY DENTAL SOCIETY

A. BERNARD ESKOW, D.D.S.

Journal Representative

The May meeting of the Baltimore City Dental Society will consist of the annual business meeting and election of the officers for the ensuing year. A pre-meeting dinner is being arranged at the Park Plaza Hotel in honor of our retiring president, Dr. Arthur S. Wheeler.

The past year under Dr. Wheeler's able direction has been a most active, stimulating and successful one. The more recent meetings consisted of such essayists as Dr. Frederick W. Herbine, Chairman, Council on Dental Trade and Laboratory Relations, American Dental Association, who spoke on "Dentists, Dental Laboratory Relations, Its Ramifications and Implications"; Dr. D. P. Mowry, Dean, Faculty of Dentistry, McGill University Dental School, who discussed "Periodontia and the Patient."

The All-Day Meeting of the city dental society was held under the able direction of its chairman, Dr. Leon Seligman, and the program consisted of four registered clinics staffed by such outstanding men as Dr. Mark A. Wallach who discussed "Operative Procedures and Pulp Therapy in Deciduous and Young Permanent Teeth"; Dr. D. P. Dobson, "Complete Dentures Using Alginate Impressions"; Dr. E. N. Gardner, "Hydro-colloid Impressions for Crown, Bridge and Inlays"; Dr. Irving Salman, "Some Phases of Oral Surgery."

The following month the society and their wives had the privilege of hearing Dr. Louis A. M. Krause, Professor of Clinical Medicine, University of Maryland Medical School, who discussed "Archaeology" following which refreshments were served.

The last scientific meeting had as its guest clinician, Dr. John C. Brauer, Dean, Dental School, University of North Carolina, whose subject, "The Child In Your Practice" was a most informative and interesting one.

Also at the present time, the Outing Committee under the direction of Dr. Frank J. Roh, is making plans for the annual outing to be held on Monday, June 22, at the Country Club of Maryland. This occasion is well attended and the men attempt to demonstrate their skill in the world of sports rather than scientifically for at least a few hours.

PHARMACY SECTION

MARYLAND BOARD OF PHARMACY

L. M. KANTNER, PHAR. D.

Journal Representative

LEGISLATION

The 1953 session of the Legislature passed two bills affecting the sale and dispensing of drugs.

S. B. 221, sub-title "Health—Dangerous Drugs," conforms with the amendment to the Federal Food, Drugs, and Cosmetic Act, referred to as the Durham-Humphrey Act.

S. B. 222 amends the Barbiturate Law by legalizing pharmacists' accepting prescriptions for these drugs by phone, as well as accepting physicians' telephoned authorization to refill them.

So amending the Barbiturate Law was reluctantly approved by the enforcement agency charged with enforcing this law. Final approval was won because it was found there was wide spread abuse by some physicians' telephoning prescriptions for Barbiturates with the understanding a signed prescription would be supplied, which in most cases was forgotten.

Another reason for approval was the Federal Law does permit such prescriptions to be accepted by phone, and by amending the State Law, confusion is eliminated. Recommendation was made to amend the Barbiturate Law by permitting prescriptions being received by phone, but holding the physician responsible to supplying a signed prescription within seven days. This recommendation was defeated as it was felt such an act would create bad inter-professional relations.

The following is the complete text of S. B. 221 dealing with so-called "dangerous drugs":

"375 A. The term "Dangerous Drugs" within the meaning of this sub-title shall mean and include any drug intended for use by man which, because of its toxicity or other potentiality for harmful effect, or the method of its use, or the collateral measures necessary for its use, is not safe for use except under the supervision of a practitioner licensed by law to administer such drugs.

"375 B. Any drug which bears a cautionary label warning against dispensing without a prescription shall be dispensed only

"(a) upon the written prescription of a practitioner licensed by law to administer such drugs, or

"(b) upon the oral prescription of such practitioner, which shall be reduced to writing and filed by the pharmacist, or

"(c) by refilling any such written or oral prescription if such refilling is authorized by the prescriber, either in the original prescription or by oral direction. Such authorization must be reduced to writing and filed by the pharmacist.

"375 C. Any dangerous drug dispensed by filling or refilling a written or oral prescription of a practitioner licensed by law to administer such drugs shall bear a label containing the name and address of the dispenser, the serial number and date of the prescription, the name of the prescriber, and, if stated in the prescription, the name and address of the patient, and the directions for use as contained in the written or oral prescription.

"375 D. The provisions of this sub-title shall not apply to sales of dangerous drugs made to registered practitioners of pharmacy, medicine, dentistry, or veterinary medicine, or to sales made by any manufacturer, wholesale druggist, or licensed pharmacist to another manufacturer, wholesale druggist, or licensed pharmacist or to a hospital or institution operating a dispensary in which a practitioner licensed by law to administer dangerous drugs is in charge, providing records of such sales are maintained, and available for inspection, showing date of sale, name and address of purchaser, and quantity purchased.

"375 E. The provisions of this sub-title shall apply to the sale by any manufacturer, wholesale druggist, retail pharmacist, or jobber of dangerous drugs, to any person, firm, corporation, association other than those legally qualified and authorized to purchase and hold same for use or re-sale, and to any practitioner's assistant who is not legally licensed to administer dangerous drugs.

"375 F. The State Department of Health is hereby authorized to promulgate necessary regulations and interpretations, not inconsistent with law, for the administration and enforcement of this Act.

"375 G. Any person, firm or corporation who violates any of the provisions of this sub-title, or refuses, neglects or fails to comply with the provisions and requirements hereof,* or fails to comply with the provisions and requirements hereof, shall be deemed guilty of a misdemeanor and upon conviction thereof shall, for the first offense, be fined not more than $250.00, for the second, or subsequent offense not more than $500.00.

"Sec. 2. And be it further enacted, That this Act shall take effect June 1, 1953."

Heretofore, there has been no State control over the class of drugs as defined in Sec. 375 A, which are unquestionably unsafe for indiscriminate use by the laity.

The refilling of prescriptions for these drugs is prohibited without the physicians authorization which may be given on the original prescription or by telephone.

It is again suggested that physicians include in their prescriptions:

Refill—(a specified number of times)

N. R.—(not to be refilled)

If this suggestion is followed, physicians will be saved much telephone annoyance.

---

* Probably a typographical error in Bill.

1953 PASSANO FOUNDATION AWARD

Source from The Passano Foundation, Inc.

Selection of Dr. John F. Enders, of Boston, as the winner of the $5000 cash award for 1953 is announced by the Board of Directors of The Passano Foundation, Inc. Now in its ninth year, this award has come to be recognized as one of the most important in the field of the medical sciences.

Dr. Enders, a native of Connecticut, is Associate Professor of Bacteriology at Harvard Medical School. Much of his research has been done at the Research Division of Infectious Diseases, Children's Medical Center, Boston, and the Department of Bacteriology and Immunology of the Harvard Medical School.

Dr. Enders received the 1953 Passano Foundation Award in recognition of his work in the development of methods for culturing poliomyelitis viruses in tissue. This is one of the most outstanding contributions to the problem of poliomyelitis since the disease was first recognized. It has cracked the problem of polio wide open.

Established in 1943 by The Williams & Wilkins Company, medical publishers of Baltimore, Maryland, The Passano Foundation is dedicated to the encouragement of medical research, especially that which has clinical application.

Dr. Emil Novak, a member of the Board of Directors of the Foundation, acted as toastmaster. An officer of the American Medical Association made an address, after which Mr. Basil O'Connor, Director of The National Foundation for Infantile Paralysis, evaluated the contribution of Dr. Enders. Presentation of the Award was then made by Mr. Robert S. Gill, President of The Passano Foundation.

* * * * *

ADVISORY COMMITTEES URGED TO EXPEDITE PROCESSING OF PRIORITY 3

The AMA Washington Letter, No. 15

To correct a situation that is resulting in some older priority 3 physicians being called to service ahead of younger men in the same group, National Advisory Committee to Selective Service is urging that all processing of this group be completed as soon as possible.

The problem arises because physicians may not be called for active duty until they have been processed to the point where they are designated as 1-A "examined and accepted," which means ready for commissioning. Because some state and local committees have not expedited processing, a number of older men whose processing is completed are being called up to fill quotas, in place of younger men, contrary to the stated policy of Selective Service and the military services.

Because processing was delayed, the age limit for duty orders has been moved upward successively from 30 to 36, then to 37 years.

Maryland
STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 2 *July, 1953* NUMBER 7

EDITORIAL

RELATIONSHIP OF BIOPSY TO DIAGNOSIS

JOHN A. WAGNER, M.D.[1]

It is now just 100 years since the idea of biopsy was introduced into the Western Hemisphere by Francis Donaldson of Baltimore. The notion that cancer could be diagnosed by the removal of pieces of tissue from the living subject had apparently been conceived in France and upon his return to America after a period of postgraduate study, Donaldson set down precise and lucid directions for the study of suspected malignant tissue, for the technique of aspiration biopsy and for the interpretation of cells scraped from the surface of a suspected cancerous lesion. The idea of biopsy, therefore, is not new.

In 1853, resistance to this innovation was apparently very great, for the cell theory of disease had not been crystallized, and indeed, the microscope was still considered by many physicians as a toy. During the ensuing century, biopsy has become an established technique in the management of neoplastic disease, largely through the development of the specialty of pathology, improvement in sectioning techniques such as the development of the microtome, and lastly, through the application of new staining techniques. The principle of the biopsy, however, has not changed. We have been able to produce better sections for study quicker, with better stains, and we are able to study these specimens more readily through improvements in the optical mechanisms of the microscope.

At the time the idea of biopsy was conceived, pathology as a specialty of medicine, had not yet evolved. With the development of departments of pathology in the medical school, application of this specialty to the management of disease gradually spread to hospitals not necessarily associated with schools of medicine. Thus, medicine gradually came to recognize the pathologist as the "doctor's doctor" and has progressively embraced the advice and counsel of these specialists in the management of neoplastic disease. Progress has been slow, and indeed, within only recent decades have the majority of the hospitals in the Western Hemisphere sought the advice and the services of a trained pathologist.

As momentous as these improvements may seem in the face of the discovery of Donaldson, the art of biopsy has not changed. We still employ the three methods originally described; namely, the removal of a small sample of the suspected growth, an aspiration of a portion of it, or the scraping away of cells from its surface. While each of the three techniques has certain advantages, an analysis of the accuracy of any of these methods, when applied to a single clinical problem, tends to eliminate aspiration biopsy and smear techniques as being too general. A diagnosis of any particular suspicious lesion rests first on the clinician's appraisal of it through a thorough physical examination and next upon his training in the gross recognition of a suspected malignant growth. Next, he must be inclined to proceed toward the removal of a portion of it for microscopic study. Next, his skill in sampling the suspected area is a most important adjunct to an accurate pathologic diagnosis. All pathologists will agree readily that the quality of a biopsy is an index to an accurate diagnosis and that the skill and understanding demonstrated by the surgeon performing the biopsy reflects directly into the quality and usefulness of the pathologic diagnosis.

---

[1] Editorial Board, Maryland State Medical Journal.

Aspiration biopsy and cytologic techniques are not new. They are not to be condemned; indeed, there are certain instances where both have a definite application either through mass survey research problems or in instances where direct vision biopsy is not possible. The concept that these techniques are new is also to be refuted. True, they have been improved, but the improvement has largely been through staining techniques.

The physician who is faced with the problem of the diagnosis of a suspected malignancy must face clearly the necessity of a careful course through enthusiasm stimulated by recrudescent activity and interest in less accurate methods of study. He should not be influenced particularly by staining techniques, variations in the basic structure of the microscope, and perhaps other innovations. He must remember that none of these has radically changed methods of medical diagnosis.

One should not close his ear and eye to progress, for indeed, a method might appear which would improve upon basic biopsy technique which depends upon the inter-relationship and cooperation from the patient who must first be taught to detect an abnormality and report it to the doctor. The physician must be taught always to remember thoroughness in his physical examination, and next, he must remember the science and art of biopsy. Next, the services of a competent trained pathologist is absolutely necessary for an authoritative and complete study of the problem.

It is not therefore the techniques employed in biopsy which are important but rather a patient-surgeon-pathologist relationship based upon scientific training, care, thoroughness, and skill. There is no substitute for a good physical examination. There is no substitute for a well selected biopsy. There is no substitute for an authoritative opinion of a competent pathologist.

CONGRATULATIONS TO THE BALTIMORE COUNTY MEDICAL ASSOCIATION

The Baltimore County Medical Association has published a Directory containing the names of the members of the Baltimore County Medical Association, with their addresses, telephone numbers, and specialties. This has been set up under localities and alphabetically. It also contains a section called, "Information of Medical Interest." This gives the names of many of the druggists by specific localities, the names of the employees of the Baltimore County Health Department, the Maryland Bureau of Medical Services and Hospitals, and the Hippocratic Oath. This is a well compiled, attractive booklet, containing valuable information.

Scientific Papers

IRON DEFICIENCY ANEMIA[1]

PHILIP F. WAGLEY, M.D.[2]

These comments are presented in four sections. The first consists of remarks on iron metabolism. The second deals with the clinical and hematological features of iron deficiency anemia. In the third section a clinical entity is mentioned that may simulate simple iron deficiency anemia, and the fourth section is devoted to therapy.

Various estimates on the so-called average daily diet place the iron content of such a diet at 5 to 17 milligrams. Some of this iron is not readily available for absorption. Some is in organic form as in porphyrin compounds and much is present as colloidal ferric hydroxide. How much iron is absorbed depends upon a variety of factors, such as the amount of acid gastric secretion, phosphates and calcium in the diet, and the amount of ascorbic acid and other reductants in the food. The acid gastric juice serves two purposes. First, at the low pH of the gastric content the ferric hydroxide molecules which tend to aggregate and polymerize are dispersed. Subsequently the ferric ions are reduced to ferrous ions at a low pH and it is in this reduction that ascorbic acid and other reducing substances are important. The ferrous salts are more soluble than the ferric salts. If the ferric ions are not reduced and absorbed, they may precipitate out with phosphate. It is apparently in the ferrous form that most iron is absorbed through the intestinal mucosa (1). Some experiments show that as much as 15 times more ferrous iron is absorbed than in the ferric form (2).

There are other factors not clearly understood that apparently regulate iron absorption. Now iron absorption is being emphasized because the body has no way of losing large amounts of iron except by blood loss (3). It has been estimated that the body may lose about 1 milligram of iron per day due to traces of iron in the bile, and still smaller quantities in the urine; apparently some loss occurs by sloughing of mucosal cells in the gastro-intestinal tract. Once iron gains admission to the body, it cannot under normal circumstances be excreted in large amounts. Injection of iron intravenously is not followed by excretion of any increased quantity, either in the urine or in the feces. Therefore, if the loss of iron from the body is only about 1 milligram a day and iron in the diet is in a range roughly around 10 milligrams a day, then normally the per cent of iron absorption in an adult male should be in the range of 10 per cent.

Obviously, it is important to understand the factors that maintain the balance between absorption of iron and the body requirements for iron. Numerous studies have been carried out to elucidate this important problem. In experiments in dogs it has been shown with radioactive isotope technique that the feeding of iron to a normal animal is associated with very little absorption. However, if the same amount of iron is fed to a chronically anemic dog (made so by bleeding) the iron is absorbed in amounts 5 to 20 times that retained normally (4). This observation has been confirmed in humans (5). This seems like a straight forward and what we would consider a normal adjustment. However, it is more complicated than it would seem to be at first. If an animal is made acutely anemic, by blood loss, and is then fed iron by mouth, the iron absorption during the first few post-anemic days is not increased (6). This apparent discrepancy between the amount of iron absorbed by an animal that is chronically anemic in contrast to one that is acutely anemic has suggested to some workers that the amount stored in various tissues of the body may control iron absorption. Thus, if a large amount of iron has been stored and is still available for hemoglobin formation it was argued that very little iron would be absorbed (6). However, as those iron stores were depleted, more and more to make hemoglobin, as in the chronically anemic animal, then iron was absorbed more readily through the intestinal mucosa. Such teleological reasoning led to more detailed study of plasma iron which is assumed to be a transport form of iron serving as a relay from the storage depots in the reticulo-endothelial system and in some parenchymal cells in the body to the bone marrow. Ordinarily plasma iron circulates in a bound form with a Beta I globulin. Normally this protein is present in concentrations of 250 to 300 milligrams per cent, one-third of which is bound with iron. The normal plasma iron level is in the range of 70 to 140 micrograms per cent. This iron level fluctuates in various types of anemia but is low in iron deficiency anemia (7). It was thus assumed that as the storage iron was depleted and used up in the formation of hemoglobin in animals bled chronically, the plasma iron began to fall and the absorption of iron was increased. This seemed to be a rational explanation until it was found that if one increases the level of plasma iron temporarily to saturation by injecting ferrous gluconate intravenously, just before feeding radioactive iron by mouth in a chronically anemic animal, there was no decrease in the rate of absorption of the radio iron (8). Furthermore, one can inject iron free Beta I globulin, that is the carrying protein for plasma iron, and thereby raise temporarily the iron binding capacity of plasma without, however, affecting greatly the actual absorption through the intestinal mucosa (1). It seems we have to assume that the plasma iron is simply a passive substance, the level of which does not influence appreciably the movement of iron from the intestines into the blood stream. Therefore, it is apparent that an essential aspect of iron absorption is still not understood.

---

[1] Read before the one hundred and fifty-fifth annual meeting of the Medical and Chirurgical Faculty of the State of Maryland.

[2] Instructor in Medicine and Anatomy, The Johns Hopkins University School of Medicine.

Let us turn our attention now to what happens to iron after it is absorbed. It apparently enters the mucosa as a ferrous ion and is incorporated with a protein that has been named apoferritin to form an iron containing compound named ferritin. It is then carried by plasma in combination with Beta I globulin in the ferric form to the bone marrow or other depots in the body. The plasma iron level does not seem to vary with age or between the sexes or with normal menstruation. There are roughly about 4.5 grams of iron in the human body. Sixty to 70 per cent of this is incorporated in hemoglobin. Three to 5 per cent is in myoglobin. Less than 1 per cent is incorporated in certain enzymes such as cytochrome oxidase, peroxidase and catylase. About 15 per cent of the iron, or one-half of that unaccounted for in the above forms, is in the form of polymerized ferric hydroxide units contained in ferritin and in hemosiderin (5).

This brings us to the mention of what has been called storage iron. As stated previously, iron may be temporarily held in tissues in the form of ferritin or hemosiderin. To recapitulate ferritin is a combination of ferric hydroxide polymerized micelles with a colorless crystallizable protein called apoferritin. Hemosiderin is apparently larger aggregates of similar material which may be easily seen microscopically (1). It is assumed that such iron moieties are available to the organism when needed for hemoglobin formation. Estimates of normal stores have been calculated and apparently such storage depots of labile iron do not become ordinarily very large (9).

So much for storage iron and to launch on the topic of hemoglobin per se would be outside the scope of this paper, so let us list the potential causes of iron deficiency. Obviously, the first is blood loss. The second is inadequate intake of iron. This may be seen in individuals on a restricted diet, either from poverty, regional dietary characteristics, or idiosyncrasies of the individual. There may be an increased demand for iron. For example in children as their blood volume increases, the amount of iron intake may be deficient and the child develop an iron deficiency anemia. Also in pregnancy several hundred milligrams of additional iron must be absorbed. Another cause for an iron deficiency anemia is impaired absorption of iron even when the intake may appear to be adequate such as in sprue, steatorrhea, and chronic diarrhea. From the remarks made previously it is apparent that achlorhydria would contribute to the impairment of iron absorption in any of these conditions.

Now in the characteristic clinical picture of iron deficiency anemia, the onset is insidious. Symptoms, on careful questioning, may date over a period of several years, prior to the establishment of the diagnosis. Hypochromic microcytic anemia is much more common in females than in males. The age range of highest incidence is between 30 and 50 years. As is common to all anemias, these patients have weakness and easy fatigability. Headache and insomnia are common complaints. Gastro-intestinal symptoms occur frequently. In approximately one fourth of these patients there is the complaint of glossitis and sometimes stomatitis. This soreness of the tongue and mouth is usually not intense, but occasionally is associated with some pain on swallowing.

As you know, physical examination of these patients usually reveals a rather listless individual in no acute discomfort. The skin and mucous membranes are pale, but there is no icterus. Such a patient may show very little weight loss and may actually be obese. There may be chylosis. Occasionally there is slight papillary atrophy of the tongue and even small ulcers on the buccal mucous membranes. There may or may not be very slight cardiac enlargement. Apical systolic murmurs are not uncommon. The spleen is palpable in about one-third of these cases. However, it does not become very large. In women occasionally one sees spooning of the nails or koilonychia.

The laboratory studies are diagnostic. As you know, the anemia of iron deficiency is characterized by a hypochromic microcytic red blood cell. The hemoglobin concentration in each red cell is low and the overall cell size is decreased. There may be a moderate amount of variation in size and shape of these red blood cells. Characteristically, this variation in size and shape does not become marked. Reticulocytes, punctate basophilia of the red blood cells and nucleated red blood cells are rarely seen unless there has been a recent acute blood loss. The white blood cells and platelets are unaffected. In the absence of iron it is obvious that hemoglobin cannot be synthesized and there is a maturation arrest at the normoblastic stage of erythropoiesis. The bone marrow, therefore, usually appears hyperplastic showing a predominance of normoblasts. Many of the nucleated red blood cells in the bone marrow contain small amounts of hemoglobin, but not enough to mature normally and consequently polychromatic normoblasts are found in increased number. There is no evidence that there is an increased rate of destruction of red blood cells in iron deficiency. The serum bilirubin and icterus index are either normal or actually diminished. The urobilinogen excretion is decreased. The life span of the red blood cells in simple iron deficiency anemia is normal. As to other laboratory studies, the urine is characteristically not remarkable. The stools should be examined repeatedly for the presence of occult blood. It should be emphasized at this point that not infrequently individuals who are losing blood through their gastro-intestinal tract may have intermittently guaiac negative stools. Consequently, repeated examinations of the stools for occult blood should be made in such individuals if the source of blood loss is not obvious.

Among the conditions that might be confused occasionally with simple iron deficiency anemia one should be mentioned here. That is thalassemia. Although severe cases were first described in 1925 (10) and separated as a disease entity from other types of anemia, it has not been until more recently that less severe instances of this disease have received a good deal of attention. Various groups have described what on first glance was a simple iron deficiency anemia, but which on further study revealed a familial tendency and was refractory to iron therapy (11, 12). Now such cases can be differentiated from simple iron deficiency anemia on the following bases. First, these patients or their ancestors usually come from the Mediterranean area. Secondly, on close questioning, or on study of members of the family, it may be found that unsuspected anemia exists among some relatives. In the severe cases the patients frequently have prominent malar eminences and epicanthal folds giving them a Mongoloid appearance of the face. In addition to pallor of the mucous membrane there may be slight icterus. The spleen is enlarged and may be sufficiently so to extend into the lower quadrants or across the midline. Less frequently, the liver is enlarged. The blood examination is quite striking. In addition to the anemia, in the severe cases, the reticulocytes are increased usually over 4 per cent. The platelets are normal in number and appearance. Frequently the white blood cell count is increased moderately and there may be a shift to the left with myelocytes and an occasional myeloblast. The most impressive change, however, on blood smear is the basophilia, stippling, nucleated red blood cells, and the appearance of the mature red blood cells. There is marked variation in size and shape of the erythrocytes with extreme pallor. Occasionally there is an accumulation of hemoglobin within the center of each cell giving it the appearance of a target cell. Now many cases have what has been described in a very mild degree with the hemoglobin ranging around 10 grams per cent. In the severe younger group of cases no really effective treatment has been discovered. These patients do not respond to iron therapy. Occasionally they seem to improve with splenectomy, but usually in the markedly anemic individuals, the course is a progressive one and the patients die of some intercurrent infection.

And now as to therapy of simple iron deficiency anemia. First and foremost it is obvious that if the patient is losing blood the source of blood loss should be treated as adequately as possible. Secondly, any chronic infection that might be present should be cleared up. For, if a person has an iron deficiency anemia, the presence of a chronic infection will impair the utilization of any iron given to that patient. Thirdly, the specific therapeutic measure is the administration of iron and it should be emphasized first and foremost that this administration of iron can practically always be carried out by oral dosage. And now what forms of iron can be used? The most popular type of iron administration is, as you know, ferrous sulphate in 0.2 gram tablets. From 3 to 6 tablets should be given per day. The medicine should be administered immediately following each meal. It should not be given on an empty stomach as it is likely to be irritating to the gastric mucosa in such concentrations. It is advisable to start out with small dosages and then increase as the tolerance allows. Ferrous gluconate is less irritating to the stomach and can be given in the same amounts. When such preparations are employed, it is not necessary to give as large amounts as are used of ferric ammonium citrate or ferrous carbonate. To treat a person with ferrous sulphate or ferrous gluconate, only costs the patient around four cents a day.

At the present time, unfortunately, there is the tendency to give "shotgun" therapy in anemia. For example, the patient may be given small amounts of iron as well as folic acid and vitamin B12 with certain other vitamins by mouth. Such therapy is not only ineffective, it is actually dangerous. In addition it is quite expensive. Some such preparations cost the patient as much as forty cents a day. In the literature, recently, quite a bit of work has been reported on cobalt

(13). It has been suggested as a possible supplementary therapeutic measure. Suffice it to say that despite some of the reports as to its hemopoietic activity, cobalt should not be used in simple iron deficiency anemia. It is very likely to cause anorexia, an unpleasant metallic taste, nausea, and vomiting.

One point should be made in this discussion and that is in iron deficiency anemia iron and iron alone by mouth is the necessary therapeutic measure. The administration of iron parenterally is practically never indicated. Such a therapeutic injection is not necessary and it is likely to have unpleasant side effects. These toxic symptoms consist of flushing, palpitation, sometimes precordial pain, nausea and vomiting. The response to iron in an uncomplicated case of iron deficiency anemia is characteristic. After a week or so of treatment the reticulocytes begin to rise. Following the reticulocyte peak the hemoglobin level increases. The rate of increase is sometimes as high as 0.2 gram per cent of hemoglobin a day. As normal values are reached, the rate of hemoglobin increase diminishes. Unless the case is complicated by continuing blood loss, or by infection or by another deficiency, the blood should be close to normal range within six weeks.

BIBLIOGRAPHY

1. Granick, S.: Iron Metabolism and Hemochromatosis, Bull. N. Y. Acad. Med. **25**, 403, 1949.
2. Moore, C. V., Duboch, R., Minnich, V., and Roberts, H. K.: Absorption of Ferrous and Ferric Radioactive Iron by Human Subjects and by Dogs. Journ. Clin. Invest. **23**, 755, 1944.
3. Widdowson, E. and McCance, R.: Absorption and Excretion of Iron Before, During and After a Period of High Intake. Biochem. J. **31**, 2029, 1937.
4. Hahn, P. F., Bale, W. F., Lawrence, E. O. and Whipple, G. W.: Radioactive Iron and its Metabolism in Anemia, its Absorption, Transportation and Utilization, J. Exper. Med. **69**, 739, 1939.
5. Wintrobe, M. M.: Clinical Hematology, Third Edition, Lea and Febiger, Philadelphia, 1951.
6. Hahn, P. F., Bale, W. F., Ross, J. F., Balfour, W. M. and Whipple, G. H.: Radioactive Iron Absorption by Gastro-intestinal Tract, Jour. Exper. Med. **78**, 169, 1943.
7. Cartwright, G. E., Huguley, C. M., Jr., Ashenbrucker, H., Fay, J., and Wintrobe, M. M.: Studies on Free Erythrocyte Protoporphyrin, Plasma Iron and Plasma Copper in Normal and Anemic Subjects, Blood **3**, 501, 1948.
8. Dubach, R., Callender, S. T. E., and Moore, C. V.: Studies on Iron Transportation and Metabolism. VI Absorption of Radioactive Iron in Patients with Fever and with Anemias of Varied Etiology, Blood **3**, 526, 1948.
9. Greenberg, G. R., and Wintrobe, M. M.: A Labile Iron Pool, Jour. Biol. Chem. **165**, 397, 1946.
10. Cooley, T. B. and Lee, P.: Series of Cases of Splenomegaly in Children with Anemia and Peculiar Bone Change, Trans. Am. Pediat. Soc. **37**, 29, 1925.
11. Wintrobe, M. M., Mathews, E., Pollack, R., and Dobyns, B. M.: A Familial Hemopoietic Disorder in Italian Adolescents and Adults, Jour. Am. Med. Assn. **114**, 1530, 1940.
12. Strauss, M. B., Daland, G. A., and Fox, H. J.: Familial Microcytic Anemia, Amer. Jour. Med. Sci. **201**, 30, 1941.
13. Berk, L., Burchenal, J. H., and Castle, W. B.: Erythropoietic Effect of Cobalt in Patients with or without Anemia, New England Jour. Med. **240**, 754, 1949.

THE ACUTE ABDOMEN*

PHILIP THOREK, M.D.†

The subject of the acute abdomen will always present an interesting challenge to the practitioner and surgeon alike. I have examined charts from the surgical services at the Cook County Hospital for a period of fourteen years, the purpose being to determine which diseases are most frequently mistaken in the acute abdomen. To my surprise I did not find fifty or seventy-five conditions which confuse us, but rather six outstanding ones that we mistake most frequently. These six conditions are:

---

* Courtesy of the Maryland Academy of General Practice. Presented before this Association at its Annual Scientific Assembly, October 9, 1952, Lord Baltimore Hotel, Baltimore.

† From the Departments of Surgery, University of Illinois, Cook County Graduate School of Medicine, Cook County Hospital, American Hospital and Alexian Brothers' Hospital, Chicago, Illinois.

1. Acute Appendicitis
2. Acute Cholecystitis
3. Perforated Peptic Ulcer
4. Acute Hemorrhagic Pancreatitis
5. Renal Colics
6. Coronary Disease

There is a seventh disease which deserves special consideration, namely, salpingitis. Acute or chronic salpingeal pathology is frequently associated with a perihepatitis which produces pain in the right upper quadrant (pseudo-gallbladder pain). Because of this, gallbladder explorations and other surgical procedures have been done in cases of salpingitis, resulting in danger to the patient and embarrassment to the surgeon.

To make a diagnosis one must have a simple and workable plan in mind. Our plan consists of four headings, namely, history, present symptom complex, physical examination and laboratory data. This routine has served us well and we utilize it daily.

ACUTE APPENDICITIS

The more one sees of acute appendicitis, the more one respects the condition. The statement "only an appendix" is indeed a dangerous one. This condition is more frequently found in individuals under the age of forty and is somewhat more common in males. It will be recalled that gallbladder conditions appear most frequently after the age of forty. The story the patient relates is usually quite stereotyped. To put it in his language: "Something I ate gave me a belly-ache." This is his way of describing acute epigastric distress. When he gets his "belly-ache" he often attempts to obtain relief with either a cathartic or an enema. Within the first twenty-four hours his "belly-ache" becomes a soreness low on the right side. His acute epigastric distress has become localized to the right lower quadrant. The "two-question test" is both useful and time-saving. Question Number 1: "Where was your pain when it started?"; to this interrogation the patient points to his entire abdomen. Question Number 2: "Where does it hurt you now?"; he then points to the right lower quadrant, usually McBurney's point. This simple method of having the patient demonstrate diffuse pain which localizes to the right lower quadrant will diagnose the vast majority of cases of acute appendicitis.

Nausea and vomiting have been impressed upon us as being associated with appendicitis. This is the exception and not the rule. Anorexia, or loss of appetite, is more constant and more important than either nausea or vomiting. Anorexia, nausea, and vomiting are three degrees of one symptom; anorexia is the mildest form and is associated with mild distention of the appendix; nausea the middle degree, is due to moderate distention; and vomiting, the maximum degree, is found in greatly distended appendices. The most common symptom in acute appendicitis is anorexia, and if the patient states that his appetite is not altered we doubt the diagnosis of an acute appendix. Two complaints which are extremely rare in acute appendicitis are diarrhea and chills. These are probably found in less than one per cent of the cases. Constipation is the rule.

Fever is not an early finding in acute appendicitis; in fact, if present it is suggestive of peritoneal soiling. It is true that cases of acute appendicitis may have a fever of 102°, or 103°, but these are no longer cases of appendicitis; they are cases of far advanced peritonitis. Children prove the exception to this rule. If appendices could be operated upon when the temperature is below 99° the mortality would be very low.

Acute appendicitis does *not* give right rectus rigidity. Although the reverse is taught in many schools and text books, this point should be clarified. It is impossible for an individual to contract his right rectus muscle without contracting the left; therefore, when pressure is made upon an inflamed area, both rectus muscles contract. When only one rectus is rigid it suggests an underlying mass, such as a tumor or abscess. When both recti contract to pressure it should be considered "muscular defense" rather than right or left rectus rigidity. The importance of this bears emphasis when we realize that diagnosis, treatment and prognosis may depend upon the presence of right rectus rigidity or simple muscular defense.

The iliopsoas and obturator signs are not signs which diagnose acute appendicitis, but rather locate an acute appendix. Probably a misconception has arisen because these signs are usually discussed under the heading of acute appendicitis; they may, however, be produced in other diseases. The right iliopsoas sign is elicited by placing the patient on his left side and hyper-extending the right leg. If positive, pain is produced over the iliopsoas fascia which will be manifested in the region of the right lower quadrant. In the presence of a history of acute appendicitis this would signify that the inflamed appendix is overlying the iliopsoas fascia and is retrocecal. A positive obturator sign will locate an inflamed pelvic appendix. It is conducted in the following way: with the patient on his back the thigh is flexed upon the abdomen and the leg upon the thigh; the leg is then abducted. This causes internal rotation of the thigh and stretches the obturator internus muscle. If this produces pain it is diagnostic of a fasciitis involving the obturator fascia, which could be caused by an inflamed tube, appendix, ovarian cyst, etc. If the patient elicits a history of acute appendicitis with a positive obturator sign, we conclude that the appendix is low-lying and in the pelvis. Rovsing's sign is also helpful. It is elicited by pressing over the sigmoid, the colonic gas which has been pushed to the right will produce pain over the cecal region; this is quite diagnostic of acute appendicitis.

Routine bi-digital examinations are done; at times an acute appendix or appendiceal mass may be felt. Late and neglected appendices may produce a pelvic abscess which points rectally or vaginally, and this examination reveals the proper site and time for incision and drainage.

The laboratory data usually consist of a white blood count and a urinalysis. More important than the white blood count or urinalysis is a differential blood count; this is easy to do and is more accurate. If the "poly" count is high, it is assumed that an acute infectious process is present; a high "poly" count in the presence of a low white count means a poor prognosis. The urinalysis is usually negative but may be misleading; a few red cells in the urine are not pathognomonic of renal pathology. Negative urines have been recorded where a renal stone completely blocks the ureter so that no blood or pus can pass into the bladder.

The reason for the high mortality in acute appendicitis can be summarized in the alliteration utilizing the three "P's", namely, Purgation, Procrastination and Poor Surgical Judgement.

ACUTE CHOLECYSTITIS

The dictum that certain types of people are predisposed to certain types of diseases seems to be correct. The gallbladder type is described as fair, fat and forty, usually being a female in the latter third or fourth decade and somewhat obese. There is always an exception to the rule, hence, the most fulminating hydrops of the gallbladder on our service was seen in a young, thin boy of sixteen. The age of forty is related to a previous history of pregnancy, and this is theoretically explained in the following way: the average female has her children in the second decade of life and while pregnant she develops a physiologic hypercholesterolemia. Some of this cholesterol deposits on the mucous membrane of the gallbladder, forms polypi which break off and become the nuclei for stones. It may take from ten to twenty years for gallstones to attain any appreciable size, so that by the time she reaches her fourth decade the stone is large enough to obstruct or irritate. Nulliparous women can also have gallstones or gallbladder disease, but this too, is the exception and not the rule.

The history of recurrent attacks of abdominal pain in a middle aged female, so severe that the physician must administer a sedative, is an acute gallbladder until proved otherwise. Acute appendicitis does not require morphine; renal colics will be differentiated presently, and coronary occlusion is rare in the female. One of the most unusual lesions noted in the female is a perforated peptic ulcer. The gallbladder patient also presents a previous history of "selective dyspepsia." By this we mean that there are certain specific foods that she cannot tolerate. There are four primary offenders to these foods: they are fried and fatty foods, raw apples, cucumbers and cabbage. The patient does not use the term "dyspepsia," but describes this distress as the two "B's": namely, bloating and belching. To summarize and describe the gallbladder patient one may use an alliteration and state that she is the patient with the seven "f's": she is the Fair, Fat, Fertile, Flatulent, Flabby, Female of Forty.

The complaint is one of pain, and it is important to determine the type of pain which is present. A constant pain is due to edema, but colicky pain is caused by obstruction. This is one of the factors which indicate whether the case should be treated conservatively or surgically. It is unwise to treat an obstructed lesion conservatively since these are cases which result in early gangrene and perforation. Morphine should not be used in gallbladder disease because it is a smooth muscle contractor, and since the gallbladder is a smooth muscle organ one should not administer a medicament which would stimulate its activity. By increasing muscle tonus, morphine may actually aggravate or provoke gallbladder pain and colic. One should not state, however, that the drug must never be used in gallbladder disease since it still has its place, namely, to prevent shock. These patients are treated first with nitrite therapy. One breaks an amyl nitrite bead and lets the patient inhale the vapors; $\frac{1}{100}$th grain of nitroglycerin is placed under the tongue, and 3 grains of sodium amytal or any other barbiturate is given by mouth. If this gives no relief we administer a hypodermic which consists of 100 mg. of demerol and $\frac{1}{100}$th of a grain of nitroglycerin. Should these measures fail, antispasmodic therapy with such drugs as papaverine, aminophylline, et cetera, is tried. Morphine is used only after all other measures have failed.

Gallbladder pain is usually located under the right costal margin, but may be referred to the stomach since these two organs originate from the same embryologic segment. The stomach responds to this stimulus in one of these types of gastric spasms: (1) pylorospasm, (2) midgastric spasm and (3) cardiospasm. If a pylorospasm is produced the gallbladder condition might be confused with peptic ulcer; if midgastric spasm results, a stomach carcinoma may be erroneously diagnosed; and if associated with cardiospasm, the pain appears on the left (pseudo-coronary pain) and coronary disease may incorrectly project itself into the diagnostic picture.

Referred pain should not be confused with radiation of pain. By radiation we mean that gallbladder pain, located under the right costal margin, may radiate along the path of the seventh intercostal nerve to the inferior angle of the right scapula, or the interscapular region. Gallbladder pain, therefore, cannot radiate to the right shoulder. Shoulder pain is an entirely different mechanism which involves the phrenic nerve and is indicative of peritonitis. When a gallbladder patient has true shoulder pain a diagnosis of gangrenous or ruptured gallbladder with biliary peritonitis should be made.

Temperature, pulse and respirations are included under the heading of physical examination. The patient with an acute gallbladder has an early high fever, hence, a temperature of 102° is not unusual within the first twelve to twenty-four hours of acute cholecystitis. The early fever is explained by the absence of a submucosa. Since this tough resisting layer is lacking, there is greater chance for early contamination and absorption in the peritoneal cavity. The patient has a pulse which is increased according to the temperature, therefore, for every degree rise in fever there will be approximately a ten beat increase in pulse rate. Respirations are slightly increased because breathing is painful. This is due to the fact that the inflamed gallbladder rubs against the sensitive parietal peritoneum; because of this, acute gallbladder disease may be confused with pneumonia or pleurisy.

Although pain, a symptom, may be referred anywhere along its nervous path, tenderness, physical finding, remains at the site of pathology. This is an excellent diagnostic rule having few if any exceptions. The tenderness of gallbladder disease will be located in the region of the right costal margin. If it is most marked on a level with the umbilicus, it may be difficult to determine whether the condition is an inflamed, low-lying gallbladder or an acute high-lying retrocecal appendix. Two ways aid in the differentiation of these two conditions. First, we recall that the normal abdomen reveals a tympanitic note to percussion in all four quadrants. If the tenderness opposite the umbilicus is due to an inflamed gallbladder, we assume that the organ is unusually large or that a ptotic liver with an inflamed gallbladder at its free border is present. This would cause an obliteration of the normal tympany in the right upper quadrant and in its place the percussion note would be one of dullness or flatness. If the patient presents tenderness on the level with the umbilicus and retains normal tympany in the right upper quadrant, this would point to a high-lying retrocecal appendix. Another method of differentiating the gallbladder and appendix is by means of Ligat's test. This test locates areas of hyperesthesia over an inflamed organ. If the tenderness is due to gallbladder disease, an area of hyperesthesia (elicited by picking up the skin and letting it drop) is present from the umbilicus upward to the right costal margin. If the tenderness is due to an acute appendix, the area of hyperesthesia will be found from the umbilicus down to Poupart's ligament.

A rectal examination is done as a routine in every physical examination. More important than the rectal or vaginal examination is a so-called bi-digital, which is conducted by placing the index finger in the vagina and the middle finger in the rectum with the perineum in between. This will immediately orient the examiner and adnexal pathology will be revealed.

A flat roentgenogram should be taken in every acute abdominal condition. One may determine whether a calcified gallbladder or visible stones are present. It also gives an indication as to whether or not the liver is enlarged or ptotic. Routine laboratory tests are done.

PERFORATED PEPTIC ULCER

This condition is rare in females. Usually a previous history of peptic ulcer or hemorrhage can be obtained, but the onset may be with perforation.

The patient states that he was seized with a sudden pain, usually after eating; this was so severe that it doubled him up. The classical picture of perforated peptic ulcer with board-like rigidity and a shock-like syndrome is too well known to bear repetition. Two signs which should be sought for in every case, however, are: (1) the findings with auscultation and (2) the presence of a pneumoperitoneum. Auscultation reveals an absolutely silent abdomen when an ulcer perforates, leaks and soils the peritoneal cavity. This is not new, since the late J. B. Murphy stressed the importance of this finding many decades ago. When intestinal sounds are present, the diagnosis of perforated peptic ulcer is remote. There are exceptions, and one of these will be discussed presently under the subject of forme fruste ulcer. The next sign which helps clinch the diagnosis is the demonstration of a spontaneous pneumoperitoneum. Normally a magenblase or stomach air bubble is present. When an ulcer perforates, this air bubble escapes into the general peritoneal cavity, and can be demonstrated either by percussion or with the fluoroscope; the latter is by far the more accurate. The patient is placed on his left side so that the free air bubble may gravitate upward between the liver and the right hemidiaphragm. By so doing, the liver is displaced downward and is separated from the diaphragm. Normally, the liver hugs the diaphragm and no air space is visible between them. If this air is of an appreciable amount, normal liver dullness is obliterated and in its place a tympanitic note is produced by percussion. The sign is easy to demonstrate, quite pathognomonic of perforated peptic ulcer, and present in about seventy per cent of all cases.

The forme fruste ulcer deserves special mention. The term refers to a pin-point perforation in the stomach or duodenum which is immediately sealed over by muscular contraction or by the overlying liver. Therefore, the spillage is minimal and the amount of peritoneal soiling is small. Such patients may experience a sudden sharp pain in the epigastrium, but the typical physical findings are lacking. The patient may be able to straighten up and walk about. Abdominal sounds are usually present and the air bubble may remain intragastric, having had no chance to leave the small perforation. These patients, therefore, present a misleading picture and have been misdiagnosed. However, with the ingestion of their next meal they usually reperforate and then present the typical findings.

The temperature, pulse and respirations will depend upon whether or not shock is present. Most perforated peptic ulcers present a shock-like picture which varies in its intensity. The shock associated with perforated ulcer responds rapidly to therapy. Within a few hours, the classical picture of peritonitis develops with the associated increase in temperature, pulse and respiratory rate.

The contents from a perforated ulcer may pass downward along the so-called "paracolic gutter of Moynihan," pool around the appendix and produce exquisite tenderness at McBurney's point. The diagnostician must then be on his guard, since such a history would suggest an epigastric distress with localization to the right lower quadrant which could be confused with an acute appendix. Upon exploratory operation, free fluid will be found in the peritoneal cavity with all signs of a peritonitis, and a red and injected appendix seen and removed. These patients usually die if the leaking ulcer is overlooked. This catastrophe can be avoided if, before closing the abdomen, the appendix is opened and the mucous membrane examined. Since acute appendicitis starts in the lumen of the appendix and travels outward, a normal appearing mucous membrane would suggest looking elsewhere for the cause of the peritonitis.

Laboratory data include the flat roentgenogram which has been discussed under the subject of spontaneous pneumoperitoneum. Routine blood count and urinalysis are done. Some of these patients might have bled, and although perforated ulcers are known not to produce massive hemorrhage, signs of a secondary anemia may be present.

ACUTE HEMORRHAGIC PANCREATITIS

It is important to recall that this disease may appear in one of two forms: either acute edematous pancreatitis or hemorrhagic pancreatitis. The former presents a mild clinical picture, but the latter which is associated with fat necrosis and occasionally a hemorrhagic peritonitis produces a fulminating one. The acute edematous form usually improves rapidly with therapy within 48 hours, but hemorrhagic pancreatitis gets progressively worse and often requires surgical intervention. It is the hemorrhagic type, therefore, which is important to identify and treat promptly.

Although the etiology of pancreatitis is unknown, there seems to be a mechanical factor which is associated with Spasm, Stones, Swelling and Stasis. Recent work seems to emphasize the relationship between acute pancreatitis and acute cholecystitis. This seems to be due to a common factor which is an obstruction distal to the junction of the pancreatic and common bile ducts converting them into a "common channel." An actual reflux of pancreatic juice into the gallbladder during an attack of acute pancreatitis has been shown. The patient who develops acute pancreatitis is usually of the same type that develops gallbladder disease, therefore, the condition is more common in females, rarely occurring before the age of forty, and is seen in stout people. The ratio of colored to white is 1 to 50. The attack usually follows the ingestion of a heavy meal. The pain is dramatic, sudden and excruciating; it is felt in the epigastrium, and radiates into one or both loins. In this way pancreatic pain radiation resembles an inverted fan. When the patient sits up or lies on his abdomen, the pain is relieved, and is aggravated when he is on his back. Hence, in most pancreatic conditions, be they tumors or inflammations, the patient is usually found lying on his abdomen or in a sitting position. Reflex vomiting or retching almost always occur; emesis which is truly reflex in nature is never feculent.

Physical examination reveals a patient who is usually in shock with cold and clammy extremities, subnormal temperature, and a rapid, thready pulse. Local epigastric tenderness is almost always present and is associated with a type of muscular defense which is localized to the same area. The rigidity is not truly boardlike in nature, and the tenderness is most marked midway between the umbilicus and the xiphoid. An occasional finding is ecchymosis in one or both loins, or at times around the umbilicus. This is due to extravasated blood which finds its way around the retroperitoneal space and presents itself as greenish yellow or purplish discolorations. This finding, however, takes two or three days to appear. Mild jaundice is present in about half of the cases; this is explained by the fact that the common duct is pressed upon by a swollen head of the pancreas. Abdominal auscultation usually reveals a quiet but not silent abdomen.

Laboratory findings may be helpful in the diagnosis. An increase of serum amylase is suggestive in the acute phase, although a normal reading does not rule out acute pancreatitis. Polowe, has emphasized the importance of determining the blood amylase activity in terms of cuprous oxide precipitation. He has shown that moderate to marked blood amylase activity is almost always associated with disease of the pancreas, and normal or decreased blood amylase almost always excludes pancreatitis. Hypocalcemia is usually present and the level found is usually below nine. A flat roentgenogram of the abdomen may reveal a separation of the upper and lower limbs of the duodenum brought about by an edema of the head of the pancreas. This latter finding is unusual.

Renal Colics

Stones are not the only substance which produce renal colics, since the same syndrome may be produced by a small blood clot, inspissated pus, uratic debris, or a kinking of the ureteropelvic junction in a ptotic kidney.

The condition is more common in males, and the patient may reveal a history of previous attacks, a hereditary influence, a story of gout, or parathyroid pathology.

The patient complains of a sudden pain which starts in the lumbar region and radiates to the testicle, vulva or the inner aspect of the thigh. With this pain he becomes extremely restless and thrashes about. A patient who is experiencing a colic is restless and moves about, but one who has a peritonitis lies perfectly quiet and resents being moved. Vomiting is a common symptom, as is a frequency of urination. During the act of micturition the pain may be altered.

Physical examination rarely reveals any elevation in temperature, but extremely characteristic of the condition is a bradycardia. It has ofttimes been stated that when a patient with an acute abdomen has "a clean tongue and a slow pulse" he has a renal colic until proved otherwise. Tenderness is most marked in the region of the twelfth rib of the involved side, and to elicit this finding it is unnecessary and cruel to utilize any type of "punch" test. The tenderness is so exquisite that mild percussion will demonstrate it. We prefer to use the term "Murphy tap" to "Murphy punch." A zone of hyperesthesia is usually found posteriorly at the level of and slightly below the twelfth rib. If this area is anesthetized with novocaine, the hyperesthesia and pain disappear.

A flat roentgenogram may reveal a stone if such is present, but this is not reliable since non-opaque substances may also produce kidney colic. An intravenous pyelogram can be made without disturbing the patient, and if necessary, the films can be taken at the bedside with the aid of a stationary grid. The significant finding for a diagnosis of a stone in the ureter is the anuria which may be present on the affected side; the opposite side shows normal excretion. The kidney on the affected side usually appears increased in density since the dye in these tubules is more concentrated. This finding is sufficient for diagnosis of non-opaque stones in the ureter. A catheterized specimen of urine usually reveals pus, blood and albumin. The presence or absence of pus and blood in the urine is not pathognomonic since a stone may completely block the ureter and result in a normal urine. On the other hand, an inflamed appendix may be attached to the ureter, kidney or bladder, resulting in a secondary ureteritis, nephritis or cystitis with an associated hematuria. In such instances the laboratory report may actually be misleading.

Coronary Disease

Although this belongs to the realm of the internist, the general practitioner as well as the surgeon must be on guard to avoid the fatal error of confusing an acute coronary disease with an acute abdominal condition.

Men are most susceptible to coronary disease, and it is found usually in those past the age of forty. A previous history of dyspnea or pain in the chest during exertion or excitement may be elicited. The attack is sudden, with severe pain in the chest which radiates out the left arm or toward the abdomen or both shoulders. There is a sense of impending death with severe fright which usually supersedes the complaint of pain. The radiation may be toward the epigastrium, so that the examiner's attention is directed to the abdomen rather than the chest. A usual complaint during such an attack is one of "indigestion." Although the pain of acute coronary disease may occur in the abdomen, it does not become localized, hence, no area of local abdominal tenderness is ever found. Marked abdominal distention may be present in coronary pathology, but muscle defense or rectus rigidity are lacking. In abdominal catastrophes the patient lies perfectly quiet, but the coronary patient resembles colic in that he is restless and tosses about. The acute cardiac patient presents veins in the neck which are distended and full, in contrast to the patient with the surgical abdomen who may appear pale and bloodless. Signs of impaired circulation are usually present, such as dyspnea, orthopnea, and cyanosis. Auscultation will usually reveal rales in both bases due to pulmonary congestion. Cardiac enlargement, feeble heart sounds and occasionally a pericardial friction rub may be found. During auscultation of the abdomen, normal intestinal sounds will be heard which are absent or diminished in cases of spreading peritonitis.

It should also be emphasized that a distinction should be made between acute coronary occlusion and acute coronary insufficiency. Acute coronary insufficiency presents itself as an episode of angina pectoris varying from simple transitory chest pain or pressure to severe pain or collapse. It is usually relieved by glyceryl-trinitrate. Coronary occlusion is the complete closure of an artery and is not influenced or precipitated by external environmental factors. It is not relieved by glyceryl-trinitrate, which may even aggravate it.

Positive electrocardiographic findings are pathognomonic, but one is not always fortunate enough to have an electrocardiogram handy. Leukocytosis may be present some hours after the disease takes place, and the urine is usually negative unless there is associated renal pathology.

It is realized that many other conditions at times require differentiation in the acute abdomen, among them strangulated hernias, regional ileitis, mesenteric lymphadenitis, mesenteric thrombosis, ruptured ectopic pregnancy, ruptured graafian follicle, ileocecal tuberculosis, vasitis, torsion of the omentum, volvulus, intussusception, etc., etc., ad infinitum. However, when one misses one of the unusual conditions he does not feel quite as responsible or guilty, as he would having missed one of the forementioned "Big Six."

25 E. Washington Street
Chicago 2, Illinois

SYMPOSIUM ON DIABETES*

GENERAL MANAGEMENT

J. SHELDON EASTLAND, M.D.

There are about 1,000,000 known diabetics in the United States and from spot surveys conducted over the United States it is estimated that there are another 1,000,000 people who have diabetes and are unaware of it. Hence the duties of the physician are two-fold: 1) treating the known diabetics, and 2) finding the unknown. The problems of detecting the unknown diabetic has been greatly intensified by the untiring efforts of the American Diabetes Association and various medical societies. A year 'round detection drive is encouraged and annually one week is set aside as Diabetes Week in which concentrated efforts are brought to play in order to increase the physicians interest and at the same time to get people to have an annual survey. These efforts bring out individuals who have few or none of the symptoms of the disease. By the early diagnosis the disease usually may be easily brought under control and many distressing symptoms and complications may be avoided.

Tonight, however, we are primarily interested in the treatment of the known diabetic. Hospital treatment, although often desirable, is by no means always essential. The diabetic patient who cannot go to the hospital need not be denied the benefits of modern treatment, for the fundamentals may be easily mastered with a little assistance from the physician. The education of a diabetic and his family is always most essential to success in treatment.

Objectives of Treatment are several:

1) To keep the urine sugar free and the blood sugar normal. Recent observations have proven that hyperglycemia per se is the factor responsible for progressive islet damage in the pancreas. It has been demonstrated that this islet-cell damage may be prevented or

---

* Presented before the Baltimore City Medical Society on Friday, February 20, 1953, at the Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore 1, Maryland.

reversed by means of proper dietary measures in conjunction with insulin.

2) To relieve symptoms.
3) To restore and maintain normal vigor and optimal body weight.
4) To enable the patient to share as completely as possible in the normal enjoyment of living. (I think this is so often overlooked.)

The basis of treatment today as in past years is the diet. However, new discoveries and changing viewpoints have profoundly influenced the type of diet advocated for the diabetic. Divergence of opinion makes it almost impossible that any single type of diet will meet with universal approval. *The fundamental principle is to avoid overfeeding*. The diabetic diet is a quantitative diet and this principle implies accurate control of the intake of food. Whether the food should be weighed or merely measured by ordinary kitchen equipment (measuring cup, tablespoon, etc.) is a matter of opinion. The diet should be palatable and satisfying both in quality and quantity. It must supply correct caloric requirements, contain proper proportions of carbohydrates, protein, fat, vitamins, and minerals. The caloric value of the diet is calculated on the patient's normal or ideal weight in Kilograms. For resting state the total calories needed can be calculated by multiplying Ideal Weight by 20. Moderate activity—multiply Ideal Weight by 30, and Strenuous activity—multiply Ideal Weight by 40. Having obtained the patient's caloric requirement the next step is to determine the number of grams of Carbohydrate, Protein, and Fat.

Example Assuming Patient's Ideal Weight is 70 Kilo.

Weight (70 Kilo.) $\times$ 30 (Moderate Activity) = 2100 Total Calories

Protein = 1 gram per Kilo (70) = 70 grams $\times$ 4 = 280 Calories

Carbohydrate + Fat (Calories) = 2100 minus 280 = 1820 Calories.

Carbohydrates = 1820 $\div$ 2 = 910 Cal. $\div$ 4 = 227 grams

Fat = 1820 $\div$ 2 = 910 Cal. $\div$ 9 = 100 grams

The task of converting grams of Carbohydrate, Protein, and Fat into terms of actual food has been greatly simplified in the "Diabetes Guidebook for the Physician" published recently by the American Diabetes Association.

This simplified method of diet calculation is based on the idea of food exchanges. The common foods allowed are divided into six groups. (Milk, Vegetable, Fruit, Bread exchanges, Meat exchanges, and Fat exchanges). In each of these groups are listed the kinds and amounts of food that have approximately the same nutritional value in carbohydrate, protein, and fat. For example, when one serving of fruit is allowed in the diet any of the fruits listed in the fruit exchange may be used in the amount specified for one serving. By the use of these food groups it is possible to calculate diet prescriptions with considerable ease. The patient is thus benefited by a diet that is made to suit his food habits along with a great variety in foodstuffs.

Nutritive adequacy of the diet is assured by including the same basic protective foods that are recommended for the normal individual—

Milk	1 pt. (adults)
Meat, fish, fowl, eggs, and cheese	4–5 ounces
Whole grain or enriched cereal or bread as prescribed	
Fruit (one citrus fruit or tomato)	2 servings
Vegetables—oen green or yellow	2 servings
Butter or fortified margarine	as prescribed

These foods should be calculated into the diet first and the remaining protein, fat, and carbohydrate may then be distributed as desired among the allowed foods. This simplified method of diet calculating is a procedure to insure the diet is adjusted to the food preferences and special requirements of the individual. "Diet lists" prepared in advance can be used for convenience provided they are modified to suit the special needs of the individual. (There are 6 sample diets (ADA) of different caloric value.)

"Specialty" foods are not recommended. They are expensive. The information, if any, of the package may be confusing and misleading. They are not needed for the diabetic can usually eat all the natural foods in the proper amounts.

Once the diet has been prepared the patient is instructed to proceed with his usual activities. I might add at this point that we are considering the ambulatory patient with uncomplicated diabetes although many of the same principles are applicable to the hospitalized patient. Diet is the first step in treatment. The second step is the qualitative urinalysis for sugar. The performance of this test by the patient at home is absolutely essential to the proper management of his disease. There are two most commonly used methods for the collection of the urine specimens—1) Four fractions daily—urine voided (a) between breakfast and lunch, (b) between lunch and dinner, (c) between dinner and bedtime, (d) between bedtime and breakfast. 2) Single specimens voided before meals and bedtime.

The use of Benedicts qualitative solution for sugar testing probably gives the most dependable results. The Clinitest tablet method is by far the most convenient and is sufficiently reliable if the reagent is fresh. A written record should be kept of each analysis and brought to the physician each visit. If the daily specimens show much sugar a quantitative analysis of a portion of the 24 hour collection of urine should be made, or blood sugar determinations can be carried out.

If any one specimen continues to show a large amount of sugar rearrangement of the diet may be tried.

When the diet, designed to correct abnormal body weight or maintain normal body weight, fails to render the urine essentially sugar free after two to three weeks the use of insulin is indicated.

The third step in treatment is the administration of insulin. Probably about 65% of the diabetic patients will require the use of insulin. Today there are four preparations of insulin commercially available. Regular or Crystalline, NPH, Globin, and Protamine Zinc insulin, differing clinically in their rate and duration of action.

The action of regular insulin is rapid in its onset reaching its peak of action about 2½ hours following injection. After about 4½ hours it rapidly begins to lose its effectiveness. Protamine Zinc onset of action is slow and the peak is not reached until about 16 hours. Then there is a slow gradual loss of effectiveness. Hence, this insulin has little value in emergencies. It is probably the insulin of choice in the mild elderly diabetic. Globin and NPH have an intermediate place as far as rate of onset and duration are concerned. At the present time I believe that NPH insulin is the most ideal preparation available.

When a single dose of insulin (regardless of type) is given the most advantageous time is before breakfast. With regular insulin probably more than one injection daily will be necessary. In the case of Protamine Zinc one daily injection will usually control the average mild case. In more severe cases a second injection will probably be necessary, and then it is best that regular insulin be given at the same time of the Protamine Zinc. By this means the glycosuria appearing during the day can be controlled.

If NPH insulin is used it is best to begin with 10–20 units given before breakfast. The dose can be increased about 4 units every three days until the urine specimen on arising or particularly a later afternoon specimen becomes sugar free. If sugar persists only in breakfast-lunch specimen about 5–10 units of regular insulin can be mixed with morning dose of NPH.

Time does not permit further details in insulin management. In conclusion, the objectives of treatment of diabetes are best attained when the blood sugar level and glycosuria are strictly controlled. This is best accomplished by measured diets and insulin.

JUVENILE DIABETES

HARRIET G. GUILD, M.D.

Symptomatology and pathological physiology are the same in the child as in the adult, but the problem as a whole is, in many respects, quite different. The features of the disease and its management that are peculiar to the child are the subject of this discussion.

1. In the child we see the disease in pure form, unmodified by contributing factors such as obesity, arteriosclerosis or life long abuse of diet.

2. Although there may be a long latent period, the disease is of congenital origin and the defect, as a result of which the child is destined to have diabetes, is inborn. Once the diabetic state comes into being, however, the development of the full blown disease picture is much more rapid than in the adult.

Example: A 2 year old child seen by us in 1948 had accidentally had a glucose tolerance test done for other reasons, with results that were within normal limits, 2 weeks before polyuria was first noted. Admitted to the hospital 3 weeks after the first complaint, the child was on the verge of acidosis with a fasting blood sugar of 300 mg.% and a typical diabetic glucose tolerance curve with blood sugar still over 400 mg.% after 5 hours.

3. Hereditary factor is important and becomes increasingly apparent the longer the patient is followed. For example, statistics regarding family history may indicate a positive history in one out of five at the time of onset, yet in the same group of patients re-surveyed after several years, the incidence of a positive family history may become as high as 3 out of 5.

Example: In one of our patients with a negative family history at onset at the age of 2, there is now, after 20 years, a positive history which includes two 'teen age maternal siblings, a younger brother and a cousin.

4. In the child the disease is always potentially severe, even though in its incipience it may seem mild. We speak of the mild *stage* of diabetes rather than of mild *cases* of diabetes. In the pre-insulin days, a child with diabetes could get along fairly well with dietary control for 6 months or a year, but thereafter it was a losing game and death usually occurred within 2 or 3 years. Since the discovery of insulin has made survival possible, we find that there is a steady increase in the insulin requirement during the first two years of the disease, after which a level is established in terms of ratio of insulin dosage to total available carbohydrate in the diet which is fairly well maintained. Hence we know that any child with diabetes will require insulin, however mild the disease may appear during the first few months.

5. The dietary requirement of the child has to allow for growth and development as well as maintenance of body weight. Calculations are, therefore, approached from a different angle and the requirement is ever changing as growth proceeds.

6. Regulation and maintenance of control in the child are complicated by his greater lability, with reference to:

a) The frequency and severity of infections
b) The ease of production of acidosis
c) Degree of activity from day to day, with effect of exercise on his metabolic state.
d) Insulin reactions

7. The problem of diabetes in the child is

always a dual problem in that one must work with both mother and child. The first hurdle is the mother's acceptance of the disease and the fact that the child will never again be without it. Furthermore, the child, who is the patient, is not initially responsible for himself.

8. In the child himself, the pattern is ever changing. Problems differ from one individual to another, according to the age and temperament of the child and may differ in the same child at different age periods. In general the younger the child at onset, the more easily is training accomplished.

9. In the child, as in the adult, vascular complications may appear after ten or more years of disease. Because of the absence of other complicating factors, however, the relationship of these to the diabetes itself is in many instances more clear cut, and cause and effect perhaps more readily perceived.

When all of the above factors are taken into account, it becomes clear that the management of diabetes in the child is an educational process starting with the onset of the disease and continuing until the child reaches full adulthood. It concerns not only the teaching of the facts of diabetes with regard to diet and insulin, but even more, the guidance and training of a human being to a certain way of life. This educational process has as its goal the production of a normal well-adjusted individual who has learned to live with a disease that is always with him and to handle it intelligently in a way that permits smooth sailing but at the same time allows a minimum of inconvenience. Since the vascular complications referred to above seem to be less frequent and less severe in those in whom good control has been consistently maintained, it involves also the acceptance of the importance of careful regulation.

Thus, regulation of the diabetic child becomes a stepwise process, in which the first step is the calculation of a diet that is optimal for normal growth and development, with the use of scales for accuracy in measurement. After the diet is calculated, an amount of insulin is given that will make it possible for the child to utilize the diet. No effort is made to avoid the use of insulin even during the mild, early stage of the disease. Such a diet should provide 60–80 calories per kg. of body weight in 24 hours, throughout the period of active growth. The carbohydrate quota averages 100–200 gm. daily (35–50% of the total calories); the protein 2½ to 3 gm per kg. of body weight; and the fat supplies the remaining calories. Usually the carbohydrate is evenly distributed among the three meals, with a small portion between meals and at bedtime, and the elements of the diet are such as comprise the general family menu.

As mother and child become oriented with regard to the basic procedures, and become familiar with the use of scales and the composition of various foods, instruction is given in substitutions and equivalents and the inclusion of special foods that the child may particularly desire, with emphasis on the importance of a well balanced diet and just passing reference to the things to be avoided.

Liberalization in the quantity of foods that do not materially alter the carbohydrate content of the diet is the next step. At this stage only the foods of high carbohydrate content are measured accurately. Finally, after several years of this regime, as good dietary habits have become established, and the disease with its hazards is clearly understood, the scales are discarded, since now the patient is prepared to select, more or less automatically, a diet that is properly balanced and suited to his needs and one that is relatively constant in carbohydrate content from day to day. It is desirable, however, at this stage to check the accuracy of estimates by careful measurement of all foods on one or two days each month.

With regard to the type of insulin used, it is usually more satisfactory to start with crystalline or regular insulin, because of its greater flexibility as compared with protamine and because most children during the mild stage can be regulated easily on two doses a day. When two doses a day no longer suffice for satisfactory regulation, a shift to protamine is made. This involves the use of both crystalline and protamine (given simultaneously before breakfast), since, at this stage, childhood diabetes cannot be controlled by protamine alone. NPH insulin has not proved very satisfactory in our hands since it also usually involves the necessity for additional crystalline insulin in the morning and often fails to control nocturnal glycosuria without a supplemental dose of insulin at supper time as well. It does, however, have its place in special cases and is most useful in those patients in whom the diabetic status has become stabilized after growth has been completed.

To achieve stability in regulation, it is desirable to permit a measure of glycosuria since insulin reactions are thus more easily avoided and allowance is then made for the variations in the child's activity. A spill of 20 gm. of sugar daily is within the limits of satisfactory regulation.

Careful regulation of the disease throughout childhood, by steps such as those outlined above, and the establishment of good habits with reference to it are essential to the child's future welfare, both physical and psychological. Furthermore, the understanding and achievement of good control creates self assurance and makes it possible for the individual to follow with confidence whatever course he chooses in study, work and even marriage.

DIABETIC EMERGENCIES; PRE AND POSTOPERATIVE TREATMENT

BENJAMIN F. JONES, M.D.

This evening I have been assigned the topic of diabetic emergencies. While there are many critical situations arising in the treatment of diabetes, the basic emergency is the development of acidosis with coma, actual or impending. Recent advances in the treatment of diabetic acidosis and coma are concerned with three topics, viz., (1) the use of insulin; (2) criteria for the diagnosis of diabetic coma and guides for therapy; (3) changes in the metabolism of potassium.

With the introduction of insulin, a dramatic fall occurred in the percentage of deaths due to diabetic coma. Further reduction in the death rate thereafter was achieved more slowly. Although clinicians knew the value of insulin in daily management of the disease, they were fearful of hypoglycemia and unaware of the decreasing effectiveness of insulin with the advance of ketosis. Today it is well recognized that insulin given in the early stages of acidosis is many times more effective than the same amount administered after the progress of acidosis and the development of coma. Cases of diabetes exhibiting great resistance to insulin have been discovered and studied. The analogy with these conditions has led many to speak of "increased insulin resistance" in keto-acidosis, although no one really understands the decreased effectiveness of insulin in any of these states. The need for large initial doses of insulin early in acidosis, however, has been clearly shown, and this constitutes a great therapeutic advance. So too is the recognition of the need for large amounts of insulin in the early hours of treatment when more extreme degrees of keto-acidosis are present.

The schedule of insulin dosage used in the treatment of diabetic acidosis and coma has been based on various criteria, including the depression of carbon dioxide content of the plasma, the elevation of the blood sugar, the urine content of sugar and acetone bodies, and the combination of these interpreted in the light of the over-all clinical picture. Joslin and his associates (1) advise the use of the blood sugar level and the depression of the carbon dioxide combining power of the plasma as guides to therapy. They recommend initial injection of 100 units of regular insulin subcutaneously for adults, if blood sugar exceeds 300 mg. per 100 c.c. and if the blood CO_2 content is 9 millimols per liter (20 volumes per cent) or less. In cases with blood sugar between 600 and 1000 mg. they would give 300 units as an initial dose and with a blood sugar of 1000 mg., they would give 400 units initially. The value of the blood sugar concentration and the carbon dioxide combining power of the blood as guides for the administration of insulin has been questioned. Certainly they are of little or no value if glucose or alkali have been used in the previous therapy.

A very useful guide to insulin therapy would seem to be the concentration of acetone bodies in the blood, including β-hydroxybutyric acid. As a routine measure, this procedure is not practical because of the time and special techniques needed for the quantitative estimation of the acetone bodies of the blood. Many years ago it was demonstrated that the Rothera qualitative test for aceto-acetic acid and acetone could be applied directly to the blood plasma. In some clinics this method in conjunction with blood sugar and plasma CO_2 levels has reportedly been used for some time as a guide to therapy in diabetic coma. It is surprising that this method has not been more widely used. So far as I know it has not been used extensively in any Baltimore Clinic. Recently Duncan (2) has reported his experience with the qualitative determination of aceto-acetic acid and acetone by this method as an aid to the early diagnosis of diabetic keto-acidosis and coma and as a guide in the treatment of coma. Ketonemia is graded as 1 to 4 plus by the Rothera test in the same way as in tests of the urine. For clinical purposes, criteria for the diagnosis of diabetic coma have been established as glycosuria and a 4 plus reaction for acetone in the blood plasma. As a guide for the dosage of insulin in coma, the acetone test is applied to undiluted plasma and to successive dilutions of plasma with normal saline to 50%, 25%, 12.5% and 6.25%. When only the undiluted plasma shows a 4+ acetone reaction, 100 units of regular insulin are given as the initial dose. A 4+ reading also at 50% dilution is the signal for an initial dose of 200 units of insulin; and the persistence of 4+ reading at 25% and 12.5% dilution calls for initial doses of 300 and 400 units of insulin respectively. In like manner the degree of ketonemia estimated in this way is followed as a guide for insulin administration in the course of further treatment. The test can be quickly carried out on a few drops of plasma obtained by allowing freshly drawn oxalated blood to stand for a short time. Commercial acetone test powders or tablets such as are used in qualitative tests for acetone in the urine may be satisfactorily used in place of the usual Rothera method. This rapid and simple procedure promises to be an important aid to all physicians concerned with the care of diabetes, whether in the home, or the office, or the hospital.

The discussion of emergencies in diabetes would be incomplete without consideration of the part played by potassium. Beginning with the original report of Holler in 1946, a series of studies has established the syndrome of potassium deficiency in diabetic acidosis as a new clinical entity. Weakness of the muscles of the extremities and of respiration progressing to paralysis and respiratory failure has been noted, with onset 2 to 12 or more hours after the start of treatment for diabetic acidosis. The clinical picture is accompanied by characteristic electrocardiographic changes and a reduced serum potassium level. Treatment with potassium salts gives prompt relief of symptoms.

During the progress of keto-acidosis, there is a great loss of both potassium and sodium from the body. In spite of this loss of potassium the homeostatic mechanisms of the body assisted by dehydration and frequently by some degree of renal failure may suffice to maintain the level of serum potassium at normal or above. In this phase, deaths have been reported of patients in diabetic coma whose electrocardiogram has shown the characteristic changes of potassium poisoning of the heart, and whose serum potassium has been found to be above the critical level of 10 milliequivalents per liter. Treatment with insulin, intravenous saline solutions and glucose solutions (though the latter is not always involved), in time depresses the potassium level below the normal of 5 milliequivalents per liter (19.5 mg.%). The critical level for the development of the electrocardiographic and clinical changes of potassium deficiency is regarded as 3 milliequivalents per liter.

There is a progressive effect of low serum potassium on the electrocardiogram.* As the serum potassium is lowered, prolongation of the QT interval is the first change seen in the electrocardiogram. The upper limit of normal for the QT interval is roughly one-half the R-R interval and both of course will vary with the heart rate.

The second change noted is lowering or inversion of the T wave and in the third stage the depression of the ST segments is seen. The final stage shows a depressed take-off of the ST segments with a low delayed T wave. The first stage may be seen at serum potassium levels of 3 milliequivalents or less. The final stage is seen with potassium levels in the range of 1.5 milliequivalents per liter or lower.

In like manner progressive electrocardiographic changes with elevation of the serum potassium may be demonstrated. The first change seen is the elevation of the T waves and this is followed by a decrease in the amplitude of the R wave. The third stage is characterized by auricular arrest and P waves are absent. At higher levels the ST segment becomes depressed and the QRS duration increases. In the terminal stage with potassium levels in the range of 9.5 to 10 milliequivalents per liter the form of the electrocardiogram becomes completely changed with biphasic curves occurring in completely irregular fashion. The level at which electrocardiographic changes are first noted with high serum potassium is approximately 6 milliequivalents per liter. Obviously some of these electrocardiographic changes are non-specific, but the patterns are characteristic and readily identified. There appears to be no correlation, however, between the level of the potassium in the serum and the degree of electrocardiographic abnormality in many cases (4).

Replacement of potassium poses a nice problem in therapy. The situation is always complex. There is no routine treatment. Experience indicates that certain procedures are relatively safe and effective on the one hand, while certain precautions are essential on the other.

The indications for giving potassium are

(1) reduction of serum potassium to 3 milliequivalents or lower

(2) characteristic electrocardiographic changes diagnostic of potassium deficiency

(3) development of weakness in the muscles of respiration and in the muscles of the extremities (recognition of the clinical syndrome of potassium deficiency)

(4) when there is a history of prolonged or severe acidosis, starvation, debility, vomiting, diarrhoea, or prolonged gastrointestinal suction, —by way of prophylaxis.

If the condition of the patient permits, potassium should be given by mouth. Three grams of potassium chloride dissolved in a pint of appropriate fluid (soup, vegetable juice or milk) provides about one half the daily average adult dietary intake of potassium. One hundred and fifty c.c. of this solution hourly (equivalent to about 1 gram of potassium chloride) can be safely given when renal function is adequate and continued till the serum potassium is within normal limits.

In urgent cases and where oral administration is impossible, parenteral treatment is necessary. Potassium chloride can be added to a liter of 5% glucose solution in amounts from 1.5 to 6 grams, giving solutions ranging in concentration from about 20 to 80 milliequivalents of potassium per liter. These solutions can be given intravenously at a rate adjusted so that 5 to 10 milliequivalents of potassium per hour (and not more than 10 milliequivalents per hour) are run in, regardless of the concentration of the solution. Parenteral treatment should be controlled by reference to frequent electrocardiographic tracings and serum potassium determinations. It should be continued until oral administration of potassium is possible or until the serum potassium is brought within normal limits. Very large quantities of injected potassium may be necessary to achieve this result, up to 30 or more grams of potassium chloride in 24 hours.

---

* See the diagrams prepared by Dr. R. S. Ross and published by Drs. J. E. Howard and R. A. Carey in the Journal of Clinical Endocrinology (3).

Potassium should not be given orally or parenterally if urinary output is impaired. Potassium should not be given parenterally unless the indications are definite and the serum potassium is known to be depressed. As a rule, potassium is not needed until several hours after insulin treatment has begun and the blood sugar begins to fall significantly. Whenever a patient is receiving potassium intravenously, means should be available for rapid treatment with calcium gluconate and intravenous glucose. Patients receiving potassium intravenously should never be left unattended.

I turn now to a more cheerful subject, the preparation of diabetics for surgical operations and their postoperative care. The aim of preoperative care is to secure a normal state of nutrition, and particularly normal carbohydrate metabolism. Adequate stores of carbohydrate in liver and muscles are a defense against ketosis and the stress of operation. So also are normal reserves of water and electrolytes and vitamins. Ideally all diabetics scheduled for elective or non-emergency surgery should be admitted to the hospital for a period of days or weeks before the operation. In these days of crowded hospitals and operating room schedules, an adequate period of pre-operative care is often difficult or impossible to arrange. In the case of diabetics, however, it pays heavy dividends in better tolerance to surgery, and in superior results of surgery, to say nothing of shortened convalescence time. We should not forget that this type of preparation can be done in the home in many cases. An attempt should be made to reduce the weight in obese patients, and often this is unusually successful when they face the prospect of operation. The value of rest and supportive care for a generous period of time is strikingly seen in the case of diabetic patients in the older age group and in those with hypertensive cardiovascular disease, malnutrition and general debility. All diabetics scheduled for elective or non-emergency surgery should be admitted to the hospital in time for routine diagnostic procedures.

For purposes of convenience these patients may be divided into three groups:

Group I

Patients whose diabetes is controlled by diet without insulin and who are able to take a diet of normal caloric content including at least 150 grams of carbohydrate. These patients require only general measures in preparation for operation. They are given no insulin or glucose preoperatively, and in the post-operative period are given insulin only as needed to control glycosuria and ketosis.

Group II

Patients who are able to avoid taking insulin by restriction of carbohydrate below 150 grams daily or who are taking 150 or more grams of carbohydrate with small amounts of insulin (up to 15 units daily). Patients in this group should be placed on a diet of 150 grams of carbohydrate, if not taking this much or more. If the patient is already taking insulin, the dose may be increased by addition of regular insulin to the PZ or NPH insulin to take care of the added carbohydrate. Patients not taking insulin should receive small amounts of NPH insulin for this purpose. This procedure can be carried out in the home in the week before operation.

Group III

Patients requiring more than 15 units of insulin in order to tolerate a diet normal in calories and with 150 grams carbohydrate or more. In this group also may be placed those patients ordinarily belonging in the other two groups, but whose condition is unfavorable because of infection or other disease. Patients in this group will profit especially by an adequate period of hospitalization prior to operation. This is obligatory when there is keto-acidosis or badly controlled diabetes. Patients with milder degrees of keto-acidosis may be treated with half the usual dose of insulin given as protamine zinc, with supplements of regular insulin as needed. The majority of patients in this group will need preoperative hospitalization for study and treatment of conditions other than diabetes, chiefly cardiovascular disease, renal disease, urinary tract obstruction or infection. Recognition of the need for restriction of metabolites (sodium and protein, e.g.) preoperatively may prevent much grief during and after the operation in this type of patient. Except in the case of patients showing frank acidosis, it is usually neither necessary nor desirable to abandon the long-acting insulin (PZ, NPH or globin insulin) in favor of frequent doses of regular insulin. Diet and insulin can usually be adjusted in a reasonable time so that the fasting and postabsorptive blood sugars approximate normal and the urine is free of ketone bodies. A moderate amount of glycosuria is permitted (10 to 15 grams in 24 hours).

Emergency operations on the diabetic can be carried out in the way outlined above and without delay or special treatment, if the patient is not in ketosis. Special care in following these patients should be exercised when their cases are unfamiliar to the attending physicians or the diabetes has been previously unrecognized. The diabetic in ketosis or coma should have vigorous treatment, while operation is postponed, till acidosis and dehydration are corrected. Antibiotics, blood transfusions, and other measures may be needed to offset the delay. Ether anesthesia should be avoided in emergency cases.

Anesthesia. The preferred anesthetic for a diabetic is the one producing the least disturbance of carbohydrate metabolism and the acid-base balance. Local or regional block anesthesia and spinal anesthesia thus should be preferred over general anesthesia. Among general anesthetics, the preferred anesthetic should be the one producing the least anoxia, the least tendency to acidosis, and the least gastrointestinal disturbance. Ether and chloroform have been shown to produce extreme hyperglycemia and acidosis. Liver glycogen is severely depleted by ether anesthesia. The requirements of the diabetic state, however, may not coincide with the demands of the surgeon and compromises must be made. Ether should be used cautiously with patients whose diabetes is controlled preoperatively and is contraindicated in keto-acidosis. Otherwise the choice of a general anesthetic should be made on the same basis as in surgery on the non-diabetic. I know of no specific contra-indication to curare unless it should happen to be used when the patient is in the hypokalemic state. Minimal doses of morphia preoperatively have been advised in diabetes because of the danger of anoxia. In my experience the tolerance of diabetics to the drug is not significantly less than that of non-diabetics.

On the day of operation a special diabetic chart is started in which will be recorded insulin, intravenous glucose and other solutions, oral feedings, blood sugar, urine sugar and ketone bodies and other significant data.

If antibiotics are being given for infection, consideration should be given to increasing the dose before operation and to changes from oral to parenteral administration after the operation. Prophylactic administration of appropriate antibiotics is indicated in diabetics before operation, especially in operations on the urinary and gastro-intestinal tract.

Operations upon diabetics should be scheduled at an early hour in the morning. Whatever the hour of operation the patient should receive an injection of insulin before operation, not later than the customary time for taking insulin. This preoperative insulin should be given in the form of protamine zinc, because of the stabilizing effect of its prolonged action. Judicious use of protamine zinc insulin may greatly facilitate negotiation of the crisis of operation. Some recommend preoperative injection of ¼ the previously required insulin in this form, others as much as one half. In my experience ⅓ the amount of insulin previously taken as PZ, or 10 units, whichever is the greater, has proved satisfactory. The important point to recognize is that every diabetic taking insulin who undergoes surgery will need an injection of insulin before going to the operating room. It is equally important to appreciate the fact that such patients will require on the day of operation as much total insulin as they were taking previously, or more.

To avoid hypoglycemia from the continuing effect of the PZ insulin taken the day before the pre-operative injection, intravenous glucose should be given. One liter of 5% glucose (50 grams glucose) should be given to patients who have received 25 units of PZ insulin preoperatively and 750 cc. to 1000 cc. of 10% glucose (75–100 grams glucose) to those receiving more. The infusion should be started just after the insulin is injected, and the rate of flow so adjusted that a substantial portion of the fluid will still be available when anesthesia is started. If the operation is long delayed, the infusion can be given in two portions, the latter starting at about the time of induction of anesthesia.

Various plans have been followed in the administration of insulin, intravenous fluids and nourishment in the postoperative period. It should be emphasized that no such plan can be safely or effectively applied without regard for the demands of the individual case and close observation of the course of events. There are many pitfalls in this jungle, and he who has more up-to-the minute data on the progress of the case and awareness of what may happen will tread with more confidence.

For the uncomplicated case, the following plan is usually effective: Total carbohydrate of not less than 150 grams is given on the day of operation and at least 3 liters of fluid. One liter of this should be in the form of normal saline, unless sodium restriction is necessary. In this case the amount is adjusted to the situation. The amount of carbohydrate given is intended to equal or exceed moderately that in the usual diet, including the portion derived from protein. The additional carbohydrate required is given in intravenous infusions beginning shortly after the end of operation and repeated every 4 to 6 hours. With the first infusion of 50 grams or more of glucose, a dose of insulin equal to about ⅓ of the estimated remaining required dose for the day (based on the patient's previous insulin requirements, and not less than 10 units) is given subcutaneously. The urine is tested every two hours for sugar and acetone by convenient rapid test methods. (Clinitest sugar and Denco or Acetest acetone tests). In this way the insulin dose is set for the next period, the aim being to avoid ketosis on the one hand and glycosuria on the other. As soon as the patient is able to take oral nourishment, liquid and soft foods are presented in feedings at regular meal times approximating his usual diet. Any deficit in intake is made up, if significant, by further intravenous glucose. PZ insulin is given daily each morning before nourishment without interruption. On successive days the patient is restored to the previous diet and insulin is adjusted by gradually increasing the PZ fraction while decreasing the regular or CZ insulin. Before discharge the patient may be shifted to NPH insulin or kept on PZ insulin alone, or supplemented by regular insulin.

In some cases the problem of postoperative care becomes extremely complicated. This is particularly apt to occur when there is much impairment of renal function, emesis or diarrhoea, and when the operation involves the gastro-intestinal tract extensively, necessitating prolonged periods of total intravenous feeding. The removal of gastro-intestinal fluid by suction also produces complex difficulties in diabetic post-operative management. In general, when nutrition is entirely or mostly by the intravenous route for a period longer than three days, it is necessary to add protein hydrolysates and soluble vitamins to the infusion fluids. A standard preparation of protein hydrolysate as the 5% solution in glucose or saline, can be given in amounts sufficient to provide the equivalent of at least 0.5 gram protein per kilogram of body weight per day. One liter of such an hydrolysate contains nitrogen approximately equivalent to 40 grams of protein. The more dilute the mixture is and the more slowly it is given, the better it will be tolerated, as intravenous administration of protein hydrolysate solution causes phlebitis. The protein hydrolysate can be given in one infusion of 8 hours or in two equal portions over a period of four hours each. Patients who have lost fluid and electrolytes by nausea, vomiting, or suction should be specially studied to determine the amounts of fluid and electrolytes needed for replacement. A special modified electrolyte solution such as that devised by Darrow or Butler containing sodium chloride, potassium, magnesium, phosphate and glucose may be used where replacement of large amounts of electrolytes is necessary. For a short period of time the situation can often be handled by addition of potassium chloride alone in amounts up to six grams daily to the saline and glucose infusions. Where total intravenous feeding with extensive replacement of protein is necessary, the patient should have special balance studies, and will fare better if placed in a ward with facilities for more elaborate metabolic studies. In patients nourished by total intravenous feeding, the management of diabetes is often a minor aspect of the total problem.

When patients exhibit unexplained ketosis postoperatively, search should be made for infection. Sometimes the onset of ketosis heralds the fact that amputation of a toe has been unsuccessful in stopping the progress of atrophy and infection. When ketosis sets in after patients have resumed oral feedings, inadequate intake of carbohydrate is to be suspected and the ketosis should be vigorously treated with additional regular insulin and forcing of carbohydrate by mouth or vein. Conversely patients who have been relieved of gangrenous and infected tissue by operation, may rather suddenly pass into hypoglycemia in the days just after the operation. In one such case, the patient was able to discontinue the use of insulin postoperatively altogether although taking about 60 units daily before the operation.

Thanks to insulin and better understanding of diabetes, thousands of diabetics are today undergoing operations successfully following a course little different from the non-diabetic. With adequate care, the mortality rate in diabetics undergoing surgery need be no greater than that in similar operations upon non-diabetics. Sprague and Wilder in 1939 at the Mayo Clinic noted 2 hospital deaths (1.8% mortality) in 109 diabetic patients undergoing cholecystectomy for cholecystitis. In the same period, 12 hospital deaths occurred amongst 703 non-diabetic patients subjected to cholecystectomy (1.7% mortality).

There are few emergencies in medicine which call for greater versatility and alertness in treatment than keto-acidosis, actual or threatened, in the diabetic, as a complication of surgery. Nothing could be more disastrous than to attempt to follow a formula or routine in these cases. The foregoing remarks are not intended as such, but rather to outline the general principles of management. The special problems presented by each case must be solved as they arise.

BIBLIOGRAPHY

1. Joslin, Elliott P., Root, Howard F., White, Priscilla and Marble, Alexander: The Treatment of Diabetes Mellitus. Ninth ed. Lea & Febiger, Philadelphia, 1952.
2. Duncan, Garfield G.: Diabetic Coma—A Therapeutic Problem. Annals of Internal Medicine, Vol. 37, Number 6, December, 1952.
3. Howard, John Eager, and Carey, Richard A.: The Use of Potassium in Therapy. The Journal of Clinical Endocrinology. Vol. #9, August, 1949.
4. Henderson, C. B.: British Heart Journal. Vol. XV, p. 87, 1953.

PERIPHERAL VASCULAR DISTURBANCES

GEORGE H. YEAGER, M.D.

Dr. J. Sheldon Eastland: Our last speaker is last in position on the program but surely is not last in the diabetic field. I think everyone who has handled any diabetes at all has been troubled with the peripheral vascular disturbances, and tonight, Dr. Yeager is going to go over some of them with us.

Dr. George H. Yeager: I think one of the greatest advantages of being on a panel of this type, is that you can look at the audience and see a gradual cerebral obtunding come over everyone. For that reason I am going to be purposely brief. I imagine we can gain a great deal more by interjecting a few points of controversy and then approach the problem of questions. I'm sure my predecessors will welcome questions and discussion.

I would like to preface my remarks with a statement that any patient presenting himself with a suggestion of a peripheral vascular disturbance should be screened for the possibility of co-existing diabetes. Frequently a patient will present minor complaints with reference to an extremity, and very often the possibility is overlooked that the symptoms may be an early manifestation of diabetes. Within a short period of time the patient may develop a rather serious infection or tissue necrosis before it is determined that the problem is that of a diabetic who may be out of control.

The subject tonight is Peripheral Vascular Disease in its components and relationship to diabetes. I am not going to discuss infections except to state that infection in the diabetic should be treated as potentially of serious consequence. Such patients should be put at bed rest and the infection should be controlled before normal physical activities are permitted.

The majority of patients from the peripheral vascular viewpoint, if they are a known diabetic, have the psychological handicap of knowing that they have a disease that is going to be with them the rest of their life. Possibly they have noticed weakness in their extremities, with limitation of ability to walk. It is serious to them because they wonder if they are going to be confronted with the end of their economic self-sustaining life.

Many patients will probably tell you that they have noticed a declining exercise tolerance for a period of months or years but didn't want to discuss it because of the possibility of jeopardizing their employment.

After ascertaining that there is a lowering of exercise tolerance, and finding evidence of organic deterioration in the vascular bed, it becomes important to evolve various lines of therapy. The first approach should be a discussion with the patient as to his general outlook.

Quite often we have a tendency to minimize the implications. Many times these patients are told simply to "repace" themselves; learn to walk more slowly and to cut down their activities. Many times they are told to give up tobacco without stressing its importance.

A patient presenting definite subjective and objective evidence of vascular disease should be screened from a number of viewpoints. The basic viewpoint should be to determine how much organic obliteration is present and how much secondary vasoconstrictive gradient is associated with the condition. By such evaluation a therapeutic approach can be developed.

With the popularity of sympathectomies the tendency probably is to sympathectomize too many patients. It is a good procedure. However, there are certain patients definitely harmed by sympathectomy. Individuals with marked stasis and loss of tonicity in their vascular bed are not going to be helped by a sympathectomy and probably are going to be harmed.

Many patients, with conservative care of their extremities and a definite regime of sympatholytic therapy, will increase their exercise tolerance and avert the necessity of a sympathectomy.

Surgery should be reserved for the group that can be promised improvement. Sympathectomy from the viewpoint of increasing exercise tolerance will probably be disappointing. In the group on whom sympathectomy is advocated, I don't believe you should tell them if they can walk a block before a sympathectomy they will be able to walk two or three blocks after their sympathectomy. I doubt it. I doubt if there is going to be any change in their exercise tolerance.

Figure 1

Therapeutic Armentarium—Peripheral Vascular Disease

DRUG	DOSAGE
Ilidar	
Regitine	50 mg.
Priscoline	25 mg.
Etamon Chloride	3-5 cc.
Roniacol Tartrate	50 mg.
Bistrium (Hexamethonium Chloride)	250 mg.
Alcohol	
I. V. Procaine—0.1%	
Paravertebral Block	
Cortone?	
Vitamine E (Ephynal Acetate; Tocophorex; etc.)	
Heparin (Treburon; Depo-heparin)	
Dicoumarol	

If a sympathectomy is going to be advocated it should be approached from the viewpoint of enhancing their collateral circulation, of enhancing their general outlook, and probably retarding the progress of their deterioration; their blockage. It is hoped to keep these people active within reason and avoid an issue of complete disability.

There was a young English doctor over here recently—some of you may have seen a movie that he presented. It was very well done. There is a large vascular clinic in Manchester, England. That clinic has an extremely large series of sympathectomized patients on whom they have performed the procedure with the hope of increasing exercise tolerance. It was found in certain groups that a large percentage of them failed to demonstrate an increase of exercise tolerance. In the group failing to respond, cutting of the tendon of Achilles was performed.

They have a series of over two hundred such cases and claim that there is very little disturbance of gait. I suggest that we review some of our historical facts. It will be found that cutting of the tendon of Achilles was one method of treatment of captives to keep them from escaping. I believe that any benefits derived from cutting of the tendon of Achilles is due to slowing down of pace; their stride has been interfered with—they are bound to walk more slowly. If we can succeed in educating these patients to repace themselves, we should not have to resort to such a radical procedure as cutting of the tendon of Achilles.

In cutting the tendon of Achilles, a factor of phlebitis has been substituted because of the stasis that develops in the posterior calf muscles. A high percentage of the patients that have had such a tenotomy developed recurring phlebitis. It is not a type of procedure that I am personally willing to advocate. However, I am sure that there are going to be many surgeons start doing it with the hope of increasing the exercise tolerance of their patients.

Intra-arterial priscoline seems to be of some value in the conservative management of vascular disease. We should recognize that vascular disease, with or without diabetes, basically presents the same problem of management. After determining that their diabetes is under control, the management of the peripheral vascular disease becomes identical. Recalcitrant ulcers, with areas of necrosis seem to demarcate more promptly, and heal with the use of intra-arterial priscoline. It is injected directly into the femoral artery in fifty milligram doses.

In the past we have all been a little apprehensive about the trauma of intra-arterial injections. It has been well proven that there is no hazard to such a mode of therapy.

Other drugs will be developed that will be as good or better than priscoline. I simply cite it as an example of the intra-arterial use of a drug compatible with more satisfactory results than has been noticed in the past.

The use of cortone probably seems somewhat contradictory. I believe that Cortone seems to be effective because it blocks out pain stimuli. I doubt if it has any effect on peripheral vascular disease, and certainly there is a great deal of evidence that it may be detrimental. We see this "blocking out" with Cortone in the toxic effects of peritonitis and toxemia.

Cortone is being used experimentally from the viewpoint that it is of value and that the exercise tolerance of these individuals can be increased.

I might interject that it is being tried in Buerger's disease. It seems to have some merit in controlling the excruciating pain of that condition.

Throughout this geographical area, the tendency is to perform a relatively conservative type of lumbar sympathectomy with extirpation over the bodies of L-2, L-3 and possibly the body of L-4. There are some groups that contend this is inadequate and that stripping should extend over L-1, and on to the 12th thoracic. They cite cases of failure of ulcers to heal with stripping of the ganglionated chain on the bodies of L-2 and L-3, and healing with a more radical operation.

We are all aware that environmental factors make a great deal of difference in our results. Many of the reported cases have been from Florida. Until a great deal more work has been done, a more extensive stripping of the ganglionated chain for a lesion in the lower extremities probably should not be widely advocated.

Dr. Eastland: The Panel has attempted to get a few of the high spots of this big subject of diabetes. I hope it has been interesting and of some value.

The hour, I know, is getting late, but if there are any questions—I see down here there is such a thing as Question Period. If there are any, I'm sure we would be glad to try and answer them. Does anyone have anything in particular? If not, we will turn the meeting back to our President, Dr. Fort.

Dr. Fort: I just want to thank each one of the members of the Panel very much for their time and effort in our behalf and I hope that maybe some time they will come back and be with us again. Thank you. The meeting is adjourned.

NICOTINIC ACID THERAPY IN VASOCONSTRICTION TYPE OF HEADACHE[1]

ZACHARIAH R. MORGAN, M.D.

Headache is one of the most common complaints encountered by a physician in daily practice. Although much has been written on headache, this subject is of sufficient interest to warrant a brief communication. In this presentation only the so-called "Migraine syndrome" will be considered.

The physiological mechanism and the many factors in the etiology of the different types of headache included in the migraine syndrome is not completely understood and there is no doubt a wide diversion of views on the cause of headaches. Although great strides have been made in the understanding of some of the etiologic factors involved and the therapeutic measures for their relief, there is still much to be known regarding this subject. Varying etiological factors have been adduced by different authors; however, Von Storck (1) has pointed out that the syndrome as a whole has a multiple pathogenesis that may be subdivided into various types in which one or another etiology is predominant. Schumacher and Wolff (2) in their experimental studies of headache, suggest that there is first a vasoconstriction of the cerebral arteries but the pain does not begin until the occurrence of dilatation of the extra-cerebral arteries, especially the branches of the external carotid artery. The latter phenomenon is the chief cause of the pain in headache. Carl Pfeiffer (et al.) (3) suggest the possibility that blood volume changes might participate in the etiology of migraine headache, and present data which they claim justify the separation from the so-called common headache into two new types, namely, relaxation headache and the caffeine-withdrawal headache. The former is accompanied by a decrease in the arterial blood volume, but the latter is attended by a relative increase in the arterial blood volume. No consistent blood electrolyte changes occur with relaxation or migraine headache. The determination of the serum proteins and hematocrit during and after migraine headache indicates that the migraine syndrome is accompanied by a relative hemoconcentration. Many other known factors in this syndrome can be correlated with changes in blood volume and peripheral vascular tone. Dreisbach (4) (et al.) corroborate the findings regarding the caffeine-withdrawal headache. Moench (5) states that in these particular individuals, with special predisposition and psychobiologic equipment that tend to create sustained pernicious emotional states and fatigue, it may be reasonable to postulate that labile physiologic mechanisms within the cranium are set off which end in the untoward chain of events constituting the attack of migraine. Wolff (6), in a psychobiologic study of forty-six migraine subjects had shown that they were so constituted as to be peculiarly prone to the development of pernicious emotional states, either sustained or with acute episodic exacerbations. In some of them a sudden increase in stress was provoked by clearly definable life situations. Such periods were associated with an increase in the intensity and frequency of attacks of migraine. He suggests that in addition to allergic, biochemical and roentgenographic studies, the personality of migraine subjects be investigated in order to determine to what extent the psychobiologic factors play in the role of their personalities.

---

[1] Read before the American Therapeutic Society, Chicago, Illinois, June 7, 1952.

It is noteworthy the role which nicotinic acid plays in the treatment and relief of the vasoconstrictor type of headache associated with depression. Although the use of nicotinic acid in the treatment of headaches is not new, it has not been sufficiently stressed in the treatment of this form of headache. Washburn (7) discusses the use of nicotinic acid in the treatment of certain depressed states. He points out that despite their varying properties and actions, the pharmacologic agents which have proved negligible in the treatment of schizophrenia, possess in common certain vasoconstricting effects, while those pharmacologic agents which tend to improve the condition have certain vasodilating effects. Many investigators (8, 9, 10) have directed attention to the fact that epinephrine, amphetamine, and ephedrine not only fail to help a patient in the so-called depressed state, but often seem to increase the severity of the symptoms, while cocaine, alcohol, sodium amytal, carbon dioxide inhalations and shock therapy have proved beneficial. Following the use of nicotinic acid in various depressed states, Sydenstricker and Cleckley (11) conclude that factors other than dietary disturbances play important roles—factors yet undetermined and perhaps unsuspected may also influence the failure of the neurones to receive and utilize an adequate supply of vitamins. Furthermore, Cleckley (12) believes it probable in some cases, that the beneficial effect observed after the administration of nicotinic acid is the result of vasodilatation rather than the correction of a deficiency state. Aring (13) likewise concludes that there is a marked increase in the cerebral blood flow following the use of nicotinic acid.

Goldzieher and Popkin (14) recommended the use of Intravenous Sodium Nicotinate in the symptomatic treatment of (a) severe ecliopathic migraine, (b) migraine and (c) post-spinal tap dephalalgia. Cachin and Beaumont (15) obtained favorable results in fifteen of the cases of long standing migraine following the use of nicotinic acid or sodium nicotinate.

It occurred to me that the use of nicotinic acid should be employed in those cases which are of the emotional or tension type of headache where Ergotamine or Dihydroergotamine (Gynergen) has failed to give relief, and which at times often increases the severity of the pain. Attention must be drawn to the fact that the pain is probably caused by vasoconstriction of the cerebral arteries rather than dilatation of the extra-cerebral arteries. So it seemed opportune to recommend this form of treatment for the vasoconstriction types of headaches associated with depression so that others may afford some relief to their patients in this variety of migraine. This paper is therefore primarily concerned with a group of patients who are not relieved by the usual drugs utilized for the treatment of headaches and whose headache is due to vasoconstriction. Five cases are reported which show favorable results over a long period. Although the number of cases comprised in this study is small, the clear-cut clinical picture of relief obtained in this group warrants further study of the vasoconstriction type of headache associated with depression.

METHOD OF TREATMENT

Intravenous Administration: Nicotinic acid was initially administered by the intravenous route to six patients. In all instances this was immediately followed by oral administration. A solution of nicotinic acid 100 mgm. in 10 cc. of sterile water was injected intravenously usually at the rate of 20 to 30 drops per minute. The rapidity of injection was determined, however, in each case by the degree of flushing and warmth which ensued, as well as any evidence of hypersensitivity or untoward reactions to the drug. The time required for the administration often varies from 10 to 20 minutes. The intravenous therapy was continued as follows: Three weeks at twice a week, three weeks at once a week, and once every other week for three doses. At the conclusion of the first treatment the patient left the office, and was given a prescription for two hundred 50 mgm. tablets of nicotinic acid together with a typed schedule of instructions for its oral use; the first dose to be taken preceding the next meal.

Oral Administration: The schedule for oral administration is as follows: (a) For the first two days, three 50 mgm. tablets are to be taken at 15 minute intervals preceding each meal. Example—breakfast hour 8:00 A.M., first tablet at 7:15 A.M., the second tablet at 7:30 A.M., the third tablet at 7:45 A.M. (b) If no untoward reaction, such as headache or nausea occurs, the dosage is to be increased on the third and fourth days as follows: four 50 mgm. tablets are to be taken before each meal, according to the fifteen minute schedule, the additional tablet being added to the first and second dosages. Example—100 mgm.—50 mgm.—50 mgm. (c) On the fifth and sixth days five 50 mgm. tablets are to be taken before each meal, the additional tablets being added to the first and second dosages. Example—100 mgm.—100 mgm.—50 mgm. (d) On the seventh and eighth days six 50 mgm. tablets are to be taken at the 15 minute schedule before each meal, two tablets being taken together. Example—100 mgm.—100 mgm.—100 mgm. Thus by the eighth day the patient was receiving a total of 900 mgm. a day. The patient was maintained on the maximum dosage for a period of one week to 10 days at which time the dosage was decreased in the same order as it had been increased. The average duration for the administration of nicotinic acid thus varied from periods of two to six weeks after which most patients were given 100 mgm. three times a day.

The rapidity of the initial relief following the use of nicotinic acid was always in proportion to the intensity of the vasomotor reaction characterized by the bright red flushing of the face, rapidly spreading over the entire trunk, tingling of the fingers and of the lower extremities and accompanied by a marked sensation of heat. After the second or third injection these side reactions gradually became less severe. All of the patients were most cooperative and there was little or no complaint about the side reactions.

One must give the drug slowly at first but fast enough to get a definite flush. So far as I have been able to find after a rather exhaustive search of the literature there seems to be no contraindication of its use.

CASE REPORTS

Case I, G. K., Age 62. Present illness began about 2 years ago, being characterized by severe headache beginning in the occipital region and neck and spreading over the head into the frontal region. Attacks last from one hour to twenty-four hours and gradually become more intense.

During the past year these attacks have become much worse and occur once or twice each week. He does not complain of any other symptoms. There is no history of dizziness, nausea, or temperature elevation.

Patient had been seen and treated at one of Baltimore's best clinics, and also examined by a psychiatrist and neurosurgeon.

Positive Findings on Physical Examination:

1. Somewhat overweight elderly white male, who did not appear ill.
2. Left testicle had been surgically removed several years before—cause unknown.
3. Evidence of mild chronic prostatitis.
4. Moderate osteo-arthritic changes in the cervical spine.

All other laboratory and x-ray examinations were negative. Ergotamine did not affect the headache. At times, sodium amytal and large doses of bromide would abort the attack.

A provisional diagnosis was made of chronic tension state accompanied by depressive features and periodic vascular head pains; Hypertrophic arthritis of cervical spine (mild); Chronic prostatitis.

The patient was given nicotinic acid as described above which has given him marked relief from the symptoms. When contacted six months ago, he was still taking 100 mgm. before each meal and he had been free of symptoms for 16 months except for an occasional mild pain which is relieved by aspirin.

Case II, Mrs. K. C., Housewife age 58, began having dull aching pain on left side of head, which in past year became so severe at times that it was necessary for her to lie down for several hours. For past three or four months these attacks had been coming on about every three or four days, and sometimes lasted from twelve to twenty-four hours. They were accompanied by dizziness, nausea and vomiting which did not afford any relief from pain.

She had been told that her trouble was due to hypertension and had had several months of treatment without relief.

Her past history is not important except that as a child she had trouble with her right hip and was put in traction for several weeks. X-ray disclosed a "flat socket" with ankylosis. She has had no discomfort for years except for mild aching when there is a change in weather. Mobility is limited.

Positive Findings on Physical Examination:

1. Somewhat overweight white female who did not appear ill.
2. Hypertension: 192/88 at rest; 210/84 two minutes after exercise.
3. Moderate osteo-arthritic changes in fingers, knees and right hip.
4. Electrocardiogram and other cardiac findings were negative.

A diagnosis was made of (1) Chronic tension state with periodic vascular head pains, (2) Mild hypertension, (3) Mild osteo-arthritis.

Patient was given Ergotamine which almost immediately caused severe head pain accompanied by nausea and vomiting. She was then started on the nicotinic acid treatment as outlined and responded with amazingly good results.

She now takes 100 mgm. three times a day and has had marked relief from symptoms. Her blood pressure now ranges from 160 to 180 systolic and 90 to 84 diastolic.

I have followed her closely for a period of one year.

Case III, Mrs. J. G., Housewife, 38 years old, had always had headache on the fourth and fifth day of menstrual period since puberty. At first, headaches were mild but gradually became more severe. For past three years, they had been coming on at any time irrespective of menstrual cycle. She was usually awakened with a headache which lasted for about 24 hours, and it was accompanied by photophobia, nausea, vomiting and a sense of depression. She has been married for several years and has two children.

Patient was treated by a psychiatrist for nine months without relief. One physician diagnosed her trouble as hypertension. She had been given ammonium chloride before her menstrual period and calcium at the onset of her period. Ergotamine seemed to intensify headache.

Positive Findings on Physical Examination:

1. Somewhat overweight female who does not appear ill.
2. Mild elevation of blood pressure: 142/96 at rest; 160/86 two minutes after exercise.

There is a soft apical systolic murmur which is transmitted to the anterior axillary line. There is some accentuation of A_2. She was begun on a nicotinic acid regime and for past year has had no further trouble. Blood pressure when last seen was 132/84. Patient is now taking 100 mgm. three times a day.

Case IV, Miss E. B., Age 45, minor executive in department store, complained of intermittent sick headaches for several years which had become worse over a period of past two or three years. Patient was usually awakened in the night by onset of headache which often lasted for two to twelve hours, and was followed by a sense of depression. These headaches were not relieved by Ergotamine, but were sometimes helped by aspirin. Three years before, she had been given subcutaneous histamine in an effort to "desensitize" her to this drug, but this gave her no relief. Psychiatric treatment was next tried which seemed to afford relief for a few months but the headaches then returned more severe than ever.

Physical examination and all laboratory findings were negative.

She was given nicotinic acid therapy about a year ago, and is still taking 100 mgm. three times a day. During this period, the patient has been entirely symptom-free; as expressed by her "I have a sense of well-being and for the first time in many years life seems worth living."

Case V, Miss F. B., Age 32, Restaurant hostess, began having severe frontal headaches which radiated into back of the head and often lasted throughout the day.

The headaches were always worse before menstruation and lately had become so severe that she had been unable to work. This was followed by a sense of depression.

Physical examination and all laboratory reports were negative except for a mild secondary anemia.

Ergotamine made the headache much worse. Ammonium chloride and a salt poor diet premenstrually did not seem to improve her condition.

She was given nicotinic acid therapy as outlined above and is now taking 100 mgm. three times a day. For the past six months she has been symptom-free.

DISCUSSION

My interest in this problem has been stimulated by the experience with a small group of patients who have received many forms of therapy for their long standing intractable headaches associated with a depression, and in whom it was possible to try the nicotinic acid therapy recommended here. The method in which the nicotinic acid treatment was administered is another point of interest worthy of clinical notice.

The general outline of therapy as recommended by Washburne (7) and in addition, the combined intravenous route with the oral route and the use of a stronger solution of nicoitnic acid was carried out in all of these cases.

Attention is called to the fact that each of these patients was first given Ergotamine by hypodermic and in four cases the pain was made much worse. In the other case, while there was no increase in the intensity of the headache, there was also no relief. Three of the cases had been given psychiatric treatment with no result. All had been treated by other physicians with many and various remedies.

While the above cases are too few and of too short a duration to draw any final conclusions, the results are encouraging. These cases set forth with particular clarity the effect of nicotinic acid therapy as outlined in this presentation. Although casual references have been made in the literature regarding the effect of nicotinic acid in the treatment of headaches, it might be of interest to point out that the usual oral therapy is often insufficient and generally leads to a stoppage of the treatment because of poor results. Furthermore, it should be noted that Ergotamine, histamine, and psychiatry have not solved the problem and that in nearly all cases the headache is accompanied by a sense of depression.

Conclusions

1. Five cases of tension headache accompanied by more or less depression are presented.

2. The method of treatment of giving nicotinic acid intravenously and combined with sustained oral nicotinic acid therapy as outlined in this communication is highly important in order to obtain good results.

3. The vasodilating effect of nicotinic acid serves to strengthen the concept that headache produced by vaso-constriction may be relieved by the use of this drug.

4. The favorable results obtained in this form of long standing headache gives convincing evidence of the use of the vasodilating effect of nicotinic acid.

5. The presentation of this small group of cases, demonstrating the apparent value of nicotinic acid, should stimulate further study of the use of this drug in the severe type of headache with depression.

BIBLIOGRAPHY

1. von Storck, Theodore J. C.: "The Migraine Syndrome," New England Jour. Med. **217,** 247, 1937.
   —— Med. Clin. N. A. **22:** 689, 1938.
2. Schumacher, George A., and Wolff, Harold G.: "Experimental Studies on Headache," Arch. Neur. and Psychiat. **45:** 199, 1941.
3. Pfeiffer, Carl, et al.: "The Etiology of the Migraine Syndrome," Jour. Lab. and Clin. Med. **28:** 1219, 1943.
4. Dreisbach, Robert H., and Pfeiffer, Carl: "Caffeine Withdrawal Headache," Jour. Lab. and Clin. Med. **28:** 1212, 1943.
5. Moench, L. G.: Headache: Test Book, The Year Book Publishers, 1947.
6. Wolff, Harold G.: "Psychobiologic Aspects of Migraine," Arch. Neur. and Psychiat. **37:** 895, 1937.
7. Washburne, Annette G.: "Nicotinic Acid and the Treatment of Certain Depressed States," Ann. of Int. Med. **32:** 261, 1950.
8. Landis, C., and Hunt, W. A.: "Adrenalin and Emotion," Psychol. Biol. **34:** 467, 1932.
9. Cameron, D. Ewen: Objective and Experimental Psychiatry, 2nd Ed., The Macmillan Co., New York, 1941.
10. Schmidt, William: "Reactivity to Ephedrine in Dementia Praecox," Munchen Med. **61:** 366, 1914.
11. Sydenstricker, V. P., and Cleckley, H. M.: "The Effect of Nicotinic Acid in Stupor, Lethargy, and Various Other Psychiatric Disorders," Am. Jour. Psychiat. **98:** 83, 1941.
12. Sydenstricker, V. P., and Cleckley, H. M., Ibid. 92.
13. Sydenstricker, V. P., and Cleckley, H. M., Ibid. 90.
14. Goldzieher, J. W., and Popkin, G. L. "Treatment of Headache with Intravenous Sodium Nicotinate," Jour. Am. Med. Assn. **131:** 103–105, May 11, 1946.
15. Cachin, M., and Beaumont, J. L.: La Semaine des Hopitaux **27:** 977, 1951.

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

Dr. John K. Rozum has terminated his residence in Cumberland and is moving his family to Miami, Florida, where he will establish a practice in general surgery.

After graduating from Medical College in June, 1931, Dr. Rozum served a residency at the Lutheran Hospital (formerly West Baltimore General), Baltimore, Maryland and came to Cumberland in 1935. For three years he has been a Chief in Surgery at the Sacred Heart Hospital in Cumberland. He is a member of the American College of Surgeons, as of 1950, Southern Medical Association, Allegany County Medical Society and Medical and Chirurgical Faculty of the State of Maryland and has served as City Physician for approximately ten years.

Dr. Rozum served with the Navy, as a Lt. Commander in World War II with the Cub 17 Unit and was in action on Guam and Okinawa.

Dr. Ralph W. Ballin, 62 Greene Street, Cumberland has returned to private practice after serving two years in the United States Army. He spent most of the time in the Fitzsimon's Army Hospital at Denver, Colorado, assigned to Ward service.

Dr. Ballin came to Cumberland in March, 1949, after being associated at the Maryland Tuberculosis Sanitorium, Sabillisville, Maryland. He graduated from the University of Cologne, Germany. He is married to the former Helen Gillaland, of Uniontown, Pennsylvania. Dr. Ballin is on the staff of the Memorial and Sacred Heart Hospital and is now conducting the chest clinic in Cumberland.

The Allegany-Garrett County Medical Society held its May meeting at the Cumberland Country Club, beginning with a Dutch treat dinner.

Dr. Frank H. J. Figge, Professor of Anatomy at the University of Maryland School of Medicine, spoke on "Recent Trends in Cancer Research and Therapy."

The following article appeared in the Cumberland Sunday Times, May 10. It is an interesting story of Cumberland's Dr. F. A. G. Murray, one of the oldest living graduates of the University of Maryland and his relationship to Queen Elizabeth II, of England.

"The Amazing Story That Starts With the Birth of George Smith at Seldsden Hall, Scotland, in 1792 and Leads to Cumberland and Westminster Abbey—To which Is Added the Story of Allegany-Garrett County Medical Society's—Dr. F. A. G. Murray."

One descendant of a Scotsman named George Smith (of Seldsden Hall), born in 1792, resides in Cumberland.

He is Dr. F. A. G. Murray, a great great grandson.

Another great great grandchild of the same George Smith resides in England.

And on June 2 that great great grandchild's daughter will be crowned in Westminster Abbey as Elizabeth II, queen of England!

The interesting story of a Cumberland physician's relationship to a Queen was told in "Across the Desk" July 20, 1947. But the coronation next month of Dr. Murray's distant cousin lends new interest to the joint genealogy of a local physician and the new ruler of the British Empire!

George Smith was a modest man of considerable means but not of noble birth. Certainly he could scarcely have dreamed that 161 years after his birth, a descendant would be the reigning Queen of England and of his native Scotland.

There were two sons born to Mr. and Mrs. George Smith of Seldsden Hall.

One was Oswald Smith whose great granddaughter (Elizabeth Bowes Lyon) married Albert, Duke of York, afterwards George VI.

The other son of George Smith was Edward Peploe Smith, great grandfather of Dr. Murray.

The step-by-step descendants of Oswald Smith follow:

A daughter, Frances, married Claude Bowes Lyon, 13th Earl of Strathmore. Their son, the 14th Earl, was the father of Elizabeth Bowes Lyon whose marriage to the Duke of York was mentioned above.

When Edward VIII (now the Duke of Windsor) gave up his throne to marry a Maryland woman (Wallis Warfield), the Duke of York became England's ruler as George VI. Their daughter Elizabeth becomes the first reigning British queen since Victoria.

Now for the genealogy of Oswald's brother, Edward Peploe Smith.

A daughter, Emily Frances (note that Frances was also her first cousin's name!) married Archibald Murray, a noted London barrister, and their son, George Mosley Murray, was the father of Cumberland's Dr. Murray.

A minister of the Church of England, Dr. Murray's father came to the United States more than 80 years ago (in 1872). He died in 1919 while rector of St. Bartholomew's Episcopal Church in Baltimore.

One of the oldest living graduates of the University of Maryland (1897) Dr. Murray first practised in Garrett County; opened an office in Mt. Savage in 1903; served as a Medical Officer in World War I, and then came to Cumberland 34 years ago. He is still active.

The Cumberland physician always kept in closer touch with the Murray side of the family than with the Smith-Bowes Lyon relatives.

Upon the death of a cousin, General Sir Valentine Murray, who was in charge of transportation for the British Army in the First World War, that last survivor of his immediate family willed his military decoration and all the ancestral family portraits to his cousin here.

Among the paintings are oil portraits of Mr. and Mrs. Charles Murray, grandparents of Dr. Murray's grandfather, Archibald Murray. There is a pastel portrait of Dr. Murray's grandmother and two of her children, one of them Sir Valentine's father.

Oldest of the family pictures received from England six years ago is one of Dr. John Murray of Norwich (born in 1720) and one of the founders of the Society of St. Andrew in Norwich. A companion portrait to the one now owned by the Cumberlander hangs in the Norfolk and Norwich Hospital in England.

Dr. Murray's grandmother (Emily Frances Smith Murray) was a first cousin of Queen Elizabeth's grandfather, the 14th Earl of Strathmore.

Incidentally Dr. Murray's full name is Francis Alan Gordan Murray.

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D., *Journal Representative*

The proposed new Constitution and By-Laws were read at the 17 April meeting in accordance with the present Constitution. These will be mimeographed and sent to City Medical Society Members ahead of the October meeting when they will be voted on. It was but a step from the Constitution and By-Laws to a discussion of the change to be proposed in the Faculty Constitution and By-Laws at the Annual Meeting. These were thoroughly discussed and procedure about them tentatively agreed upon.

Dr. George Thorne gave the Kolson Memorial Lecture in the Hurd Hall that same evening and provided a good deal of competition. Dr. Thorne's talk was a return to his old stamping grounds and was well attended.

The Cardiology Postgraduate Course wound up successfully. The series of talks was appreciated by City Society Members. Thanks to the Union Memorial Hospital for the use of the hall. Orchids to the good lecturers.

A postgraduate committee is in the process of formation. It is anticipated that postgraduate courses on other themes may be given in the Fall. If the Fall meeting is as well attended as this Spring one has been, President Fort anticipates quarterly courses on a series of major topics. The names of this Postgraduate Committee have not been released.

A joint Committee on Anesthesia Mortality has been set up. Composed of members of the City Health Department and the City Medical Society, it is conceived in the same cooperative spirit as the Joint Committee on Maternal Mortality. The Anesthetic Mortality Committee will be composed of 12 members, three at least, will be anesthetists in active practice. Ex-officios will be Chairman of the Anesthesia Section of the City Medical Society, President of the Baltimore Hospital Conference, Professors of Anesthesia at Hopkins and University Hospitals, the Chief Medical Examiner or a member of his staff and Health Commissioner of Baltimore City or his representative. The Chairman will be designated by the President of the Baltimore City Medical Society. Names are not yet available for publication but will be released probably before this goes into print.

Another new development is an outgrowth of the Faculty's Joint Committee on Medicolegal Problems. A list of Specialists in their respective fields is being prepared for the use of judges and magistrates of Baltimore City. The judicial authorities feel the need of specialized advice and support in certain problems of a medical nature.

The State Annual Meeting was held April 27, 28, 29. It has been reported in full in other sections of this Journal. It was a most delightful meeting and much credit is due the Auxiliary for the Medical Ball on Monday night and the Art Exhibit. Great work went into the preparation of these features. They gave enjoyment to many people.

A Medical Section of the City Society is finally in the process of organization. The merits and demerits of such a move have been under discussion ever since Blue Shield started. An organization meeting 12 May elected Dr. Francis Gluck, Chairman, Dr. T. Nelson Carey, Vice-Chairman, Dr. Ernest C. Brown, Jr., Secretary, and Dr. Katherine Borkovich, Treas-

Dr. W. B. Campbell Dr. Lewis K. Woodward, Sr. Dr. Louis J. Hirschman

urer. A second meeting is planned for 16 June at which time policies and committees should be decided on.

CALVERT COUNTY MEDICAL SOCIETY

PAGE C. JETT, M.D.

Journal Representative

"The new Calvert County Hospital was dedicated on May 16, 1953. This hospital, costing approximately $800,000 was completed in March 1953. It has facilities for thirty patients but can be rapidly expanded to accommodate fifty patients. This hospital was built with local and Hill-Burton funds and represents the latest in design and appointments for a one-story rural hospital with facilities for white and colored patients. All are cordially invited to visit our new hospital."

CARROLL COUNTY MEDICAL SOCIETY

75 YEAR-OLD MARYLAND DOCTOR HONORED AT RICHMOND

At First Western Hemisphere Conference of the World Medical Association, at Richmond, Va., April 21–25, three medical school graduates of 1899 compare notes on medical progress since that time: l. to r.: Dr. W. B. Campbell of Waukesha, Wisconsin; Dr. Lewis K. Woodward, Sr. of Westminster, Maryland; and Dr. Louis J. Hirschman of Traverse City, Michigan.

These 75-year-old doctors, with 45 others, were designated by the Governors of their respective states as guests of honor. The theme of the Conference was Medicine's Achievements in lengthening life and improving health. A grant to the World Medical Association by A. H. Robins Co., Inc., of

Richmond covered conference expenses. From: World Medical Association.

PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

JOHN WARREN, M.D.

Journal Representative

At the April meeting, Dr. Alfred Suraci, one of our associate members, presented slides on his topic, "Problems in Reconstructive Surgery." Dr. Suraci showed us many of the new plastic materials that are now being used in his specialty.

In May we heard from Dr. Alan D. Miller of the United States Public Health Service's Mental Hygiene Clinic. Their unit, located in College Park, is one of the few experimental clinics which is still operating and serving the people of local communities.

Dr. and Mrs. Julius Kauffman had a very enjoyable cocktail party and the society was so well represented that they took the opportunity to hold an Executive Board meeting at which Dr. Wolcott Etienne was named to the Board of Directors of Prince George's Hospital. Under a new law just passed by the Maryland Legislature, the lay member selected was Mr. Ralph F. deClairmont of Mitchellville. Dr. Waldo B. Moyers, another member of the society, had already been chosen by the medical staff as its representative on the board. Dr. Moyers, who laid much of the ground work as Chairman of the Society's Legislation Committee, agreed to represent the hospital's medical staff for one year.

Dr. William Stecher, hospital radiologist, Harry Penn, hospital superintendent, and Dr. Harry Ferris, associate member in dentistry, have each given talks over Station WNAV on our program, "Community Medicine Today."

The Prince George's General Hospital's Assistant Superintendent and Treasurer, David A. McNamee, has resigned his post effective May 25. Mr. McNamee leaves to enter the Georgetown University Law School but will retain his post with this society as Executive Secretary.

150 MEDICAL GRADUATES IN ARMY'S INTERN PROGRAM

THE AMA WASHINGTON LETTER, NO. 16

A total of 150 June medical school graduates have been selected for the Army's medical intern program. All will be assigned to one of the Army's 11 teaching hospitals. The men will serve as first lieutenants in the Reserve. The largest groups, 21 each, will go to Brooke Army Hospital at Fort Sam Houston, Texas, and Walter Reed, Washington, D. C.

ADD TO LISTS OF LIBRARY AND FILMS CLEARED FOR TV

AMA NEWS NOTES, VOL. 2, NO. 5

Supplementary lists of films cleared for television and films available through the AMA's motion picture library now may be obtained from the Committee on Medical Motion Pictures. One supplement lists 38 health education films cleared for TV since publication of the original list in 1951. The other includes 12 motion pictures added to the library since the December, 1952, catalog was published.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

BOOKS ON GOUT

LOUIS KRAUSE, M.D.*

This month, we are presenting the books on GOUT. You will note that the list is large and dates back to earlier days. Gout is frequently overlooked in everyday practice; and how little do we hear of the terms of *Podagra*, which is gout in the big toe, and *Cheiragra*, which is gout in the wrist, or *Gonagra*, which is gout in the knee. In all likelihood, terms of this kind always kept the possibility of gout in the minds of the older clinicians; and for that reason, they may not have overlooked the diagnosis as frequently as we do today. Incidentally, these are the terms used by Hippocrates.

Our treatment with Colchicine really dates from the 5th century and the word gout dates from the 13th century coming from the French *Goutte*, signifying a drop and implying at the time that there was a poison that entered the joints drop by drop. The best clinical description is still the one by Sydenham who lived in the 17th century.

Today, of course, we are looking not only for primary gout, the "inborn metabolic error," but also for the secondary forms that we see in leukemia, nephritis, etc. The appended list of books in our library will prove an excellent source for information on this anciently known disease.

BOOKS ON GOUT IN THE MEDICAL AND CHIRURGICAL FACULTY LIBRARY

A Selected List

Barker, L. F. and Cole, N. B., Rheumatism; its meaning and its menace. New York, 1926.

Buckley, C. W., Arthritis, fibrositis and gout. London, 1938.

Cadogan, W., A dissertation on the gout, and all chronic diseases, jointly considered, as proceeding from the same causes. London, printed; Boston, reprinted, 1772.

Chapman, N., Lectures on the more important eruptive fevers, haemorrhages and dropsies, and on gout and rheumatism. Philadelphia, 1844.

Charcot, J. M., Maladies des vieillards, goutte et rhumatisme. Paris, 1890.

Chomel, A. F., Leçons de clinique médicale, v. 2, Rhumatisme et goutte. Paris, 1837.

Cohausen, J. H., Epistola responsoria epicritica, clarissimo et experientissimo domino Salentino Ernesto Eugenio Cohausen. Frankfurt and Leipzig, 1749.

Delpeuch, A., La goutte et le rhumatisme. Paris, 1900.

Desault, P., Dissertation sur la goutte. Paris, 1738.

Dickinson, J. C., On the tonic treatment of gout. 2nd ed. London, 1871.

Duckworth, D., A treatise on gout. London, 1890.

Duringe, M., Monographie de la goutte. 4th ed. Paris, 1830.

Ebstein, W., Die natur und behandlung der gicht. 2nd ed. Wiesbaden, 1906.

Ewart, W., Gout and goutiness. New York, 1898.

Fuller, H. W., On rheumatism, rheumatic gout and sciatica. London, 1852 and 1854, Philadelphia, 1864.

Gardiner, J., An inquiry into the nature, cause and cure of the gout. Edinburgh, 1792, Philadelphia, 1793.

Garrod, A. B., Treatise on gout and rheumatic gout. 3d ed. London, 1876.

Grimke, J., Dissertatio medica inauguralis de podagra. Edinburgh, 1808. (Thesis)

Gros, E. L., A modern pathological and therapeutical study of rheumatism, gout, rheumatoid arthritis and allied affections. New York, 1897.

Halle, J. N., Rapport sur les effets d'un remède proposé pour le traitement de la goutte. 2d ed. Paris, 1810.

Hardy, J., A candid examination on the colic of Poitou and Devonshire; with remarks on the gout. London, 1778.

---

* Chairman, Library Committee.

Hood, P., A treatise on gout, rheumatism and the allied affections. London, 1871.

Jones, H. B., On gravel, calculus and gout. London, 1842.

Lecorche, E., Traitement de la goutte. Paris, 1894.

Levison, F., Uric acid diathesis, gout, sand and gravel. London, 1894.

Lindsay, J., Gout, its aetiology, pathology and treatment. London, 1913.

Llewellyn, R. L. J., Aspects of rheumatism and gout; their pathogeny, prevention and control. London, 1927.

Llewellyn, R. L. J., Gout; with a section on ocular diseases in the gouty by W. M. Beaumont. London, 1920.

Longstreth, M., Rheumatism, gout and some allied disorders. New York, 1882.

Loomis, A. L. and Thompson, W. G., ed., System of practical medicine, v. 4. New York and Philadelphia, 1898.

Lucianus Samosatensis, Podagra tragice producta a Luciano. 1631. *In* Sennert, D., De arthritide tractatus. 1631. p. 109–132. Text in Greek and Latin.

Luff, A. P., Gout, its pathology and treatment. London, 1899.

Noorden, K. H. von, Technique of reduction cures and gout. New York, 1910.

Proust, A. A. and Mathieu, A., L'hygiene du goutteux. Paris, 1896.

Revere, J., An inquiry into the origin and effects of sulphurous fumigations in the cure of rheumatism, gout, etc. Baltimore, 1822. (Medical pamphlets, v. 3).

Richardière, H. A., Maladies de la nutrition, goutte—obésité—diabète. Paris, 1913.

Roberts, W., On the chemistry and therapeutics of uric acid, gravel and gout. London, 1892.

Roose, R., Gout; its relations to diseases of the liver and kidneys. 7th ed. London, 1894.

Ruhräh, J., William Cadogan (His essay on gout). New York, 1925.

Ruppaner, A., Hypodermic injections in the treatment of neuralgia, rheumatism, gout, etc. Boston, 1865.

Scot, J., An enquiry into the origin of the gout. 3d ed. London, [n.d.]

Scudamore, C., A treatise on the nature and cure of gout and rheumatism. 2d ed. London, 1817.

——, A further examination of the principles of the treatment of gout. 2d ed. London, 1833.

Sennert, D., De arthritide tractatus. Wittenberg, 1631.

Spilsbury, F., On the scurvy, gout, diet and remedy. 5th ed. Norwich, 1790.

Sydenham, T., Abhandlung über die Gicht (1861), eingeleitet und übersetzt von Julius Leopold Pagel. Leipzig, 1910.

Thomson, F. G. and Gordon, R. G., Chronic rheumatic diseases, their diagnosis and treatment. London, 1926.

Todd, R. B., Practical remarks on gout. London, 1843.

Voet, D., Dissertatio medica inauguralis de podagra, sive pedum dolore. Heusden, 1690.

Warner, F., A full and plain account of the gout. 2d. ed. London, 1768.

Wilde, P., The physiology of gout, rheumatism, and arthritis. New York, 1922.

HOW CAN THE LIBRARY HELP YOU?

The Library stands ready to serve the members in any way possible.

Do you want recent articles on the estrogenic treatment of cancer of the lung, or on eyeground changes in toxemia of pregnancy, or on some other clinical condition? Would you like Aub's original description of lead poisoning, or some other historical material? Do you need the address of a pediatrician in St. Louis, or a dermatologist in Little Rock?

The county members especially are urged to make more use of the Library. Requests by letter or telephone are answered promptly, and material is mailed out within twenty-four hours if at all possible.

Suggestions as to books the Library should purchase, and ways in which it can be more useful to members, will be much appreciated by the Library Staff.

REPORT FOR THE BOARD OF TRUSTEES OF MARYLAND MEDICAL SERVICE, INC.[1]

HUGH J. JEWETT, M.D., *President*

Maryland's Blue Shield Plan has come a long way in its two brief years of existence. It now serves 197,000 Marylanders, 37,000 more than at the end of 1951. Our enrollment gain for 1952 under the standard program was 50 percent, and nearly half of this gain came after September 1, when changes in the fee schedule and subscription rates materially improved the attractiveness of the Plan. The Plan's income in 1952 went over the million dollar mark and of this amount, 83.6% was paid in benefits to subscribers. Compared with the early record of Blue Cross—a remarkable story of progress in itself—our growth has been steady and healthy, and a certain amount of optimism seems justified.

Despite its successful progress, Blue Shield still has far to go to meet its basic obligation—an adequate and effective means of financing physicians' services for as many persons in the community as possible, at a price they can afford to pay.

Let us analyze this objective. Is the protection adequate? It seems as nearly so as we can make it right now, although in time we will probably wish to broaden it. Last year we paid benefits to about one in every ten persons enrolled. Of these cases, under our own Plan (excluding the special surgical program for Bethlehem Steel employees) 60% of the cases involved surgery, 31% were medical, and the remaining 9%, obstetrical. These figures show the importance of our medical coverage, which is not always available elsewhere under Blue Shield, or commercial insurance programs.

Is the price one the great majority can afford to pay? Apparently it is, judging from our own experience and that of Blue Shield Plans in other areas. Whether it could be increased in order to broaden benefits is a question that must some day be studied.

But what of our objective to make Blue Shield available to as many persons as possible? Here we have only scratched the surface of our potential market. We have enrolled only 22% of the Blue Cross membership. A tremendous selling job remains to be done, and this is not easy, since we find that in the majority of large groups we have to replace an existing commercial coverage taken out in the years before Blue Shield was in existence.

One of the most important features of Blue Shield—one that could and should be the most important—is the service benefit feature whereunder participating physicians agree to make no additional charge for covered services to individuals and families with annual incomes less than the pre-established amounts.

This is the one factor that distinguishes Blue Shield from commercial health insurance.

To persons in the lower income brackets, this service benefit feature means full protection against unexpected medical bills. They get the best medical care, and are able to budget for it in advance through membership in Blue Shield.

In agreeing to provide services at pre-determined fees to persons in the lower income brackets, the physician is not deviating from the established practice of charging patients according to their ability to pay. At the same time he is providing real service to the community.

The phenomenal growth of Blue Shield—24 million members nationally—has been one of the chief factors (along with the growth of Blue Cross) in persuading the proponents of Federal compulsory health insurance that the provision and financing of medical care for the self-supporting population can be achieved on a voluntary basis.

Blue Shield is our creation. It is controlled here and elsewhere by the medical profession. We collect the money and undertake to provide the services of qualified physicians, which is right and proper since our interest is paramount. But with our control goes responsibility, and with responsibility goes opportunity. If any other agency, in or out of Government, undertook to provide the public with professional services, we would lose control of medical practice.

---

[1] Read before the House of Delegates of the Medical and Chirurgical Faculty, April 27, 1953.

The continued success of Blue Shield will depend entirely upon the degree of our voluntary cooperation and participation. Hence, we must endorse Blue Shield to our patients and friends. By so doing we will bring the program closer to its objective—an adequate and effective means of financing medical care for as many persons as possible at a price they can afford to pay—and we will have rendered a real service to our patients, to the community, and to ourselves.

AMA OFFERS TWO NEW EXHIBITS

AMA NEWS NOTES, VOL. 2, NO. 5

Two new exhibits will be available for showing at state medical society meetings this fall, the Bureau of Exhibits reports. One exhibit—"Accidental Poisoning in Children"—is based on authentic fatal accident cases, while the other—"A Medical Service Program for your Community"—covers various activities of medical societies and voluntary and public health agencies.

The exhibit on accidental poisonings, from the Committee on Pesticides, emphasizes points of danger in the home, yard and selected farm locations. When staffed with trained personnel, this makes an effective showing at public gatherings, state and county fairs, food and home shows. Subjects included in the exhibit developed by the Council on Medical Service range from care of the chronically ill to hospital construction, physician placement, and rehabilitation.

Both exhibits require space 10 feet long and six feet deep—or, if shown in extended fashion, 20 feet long and three feet deep. Requests for bookings may be made to the Bureau of Exhibits after June 15.

HOW TO GET A DOCTOR—BOOKLET AVAILABLE SOON

AMA NEWS NOTES, VOL. 2, NO. 5

A new pamphlet—"A Doctor for your Community"—will be published some time in June by the American Medical Association. This booklet, directed toward communities seeking a physician, describes briefly the problems involved in obtaining a doctor, the things a community can do to attract and keep a doctor, and examples of what has been done elsewhere. A joint project of the Council on Medical Service, Council on Rural Health and Department of Public Relations, the booklet will be available to state medical societies for distribution to communities listed with their placement services.

In addition, the Council on Medical Service has compiled information from numerous state placement services in a reprint which will be especially useful to state societies interested in expanding their activities in this field.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. CHARLES H. WILLIAMS, *Auxiliary Editor*

ANNUAL REPORTS OF THE COMPONENT AUXILIARIES

WOMAN'S AUXILIARY TO THE BALTIMORE COUNTY MEDICAL ASSOCIATION

MRS. THOMAS E. WHEELER*

Our Auxiliary has been very active since the last meeting of the Woman's Auxiliary to the Medical and Chirurgical Faculty, with the following accomplishments to report:

1. In June of 1952, the Auxiliary was invited to attend a joint meeting with the Baltimore County Medical Association at which time our second student nurse received her scholarship award; and awards were presented for the Medical Association Emblem. (A contest was sponsored in the Baltimore County High Schools by the Baltimore County Medical Association.)
2. September found our Auxiliary very busy with an exhibit at the Timonium Fair. Free movies, "Your Doctor," and "Frontier in Medical Research," were shown. Two student nurses from the University Hospital were on duty to give free blood pressure examinations. Approximately 10,000 pieces of literature were distributed by two doctors' wives, on a four hour shift. Baltimore City Auxiliary members joined with the Baltimore County Auxiliary to make this project a success.
3. The Auxiliary again joined the Baltimore County Medical Association as luncheon guests of the Rosewood State Hospital. Election of officers was then held.
4. Executive meetings were inaugurated to be held as necessary to expedite business so as to allow the regular meetings of our Auxiliary free for more social programs.
5. March 28, 1953, was set aside for our third annual Doctors' Day celebration. A dinner-dance was held at the Sheraton-Belvedere Hotel. The evening proved to be most enjoyable, with a wonderful attendance and a great financial success. Proceeds of this affair will be used to sponsor our third nurses' scholarship fund.
6. Our Nurse Recruitment Chairman is very active supplying Future Nurses of America Clubs; in the Baltimore County High Schools; with program material and suggestions, also in starting clubs in any schools where students are interested in nursing.

WOMAN'S AUXILIARY TO THE BALTIMORE CITY MEDICAL SOCIETY

MRS. ALBERT E. GOLDSTEIN*

The Woman's Auxiliary to the Baltimore City Medical Society has had a very interesting and constructive program for 1952 and 1953.

The Nurse Recruitment committee has been very active throughout the year.

A two part program has been planned:

1. To interest young girls in nursing as a career.
2. To make it possible for inactive registered nurses to offer their services to the community.

A film is being made on nurse recruitment that will be of interest to high school girls. The medical and nursing directors of all Baltimore hospitals with training schools were contacted and the State Nurses Association was represented. Mr. Carroll D. Hill, Director of Union Memorial Hospital accepted the chairmanship of finance. Twenty-five hundred dollars was contributed which will cover the cost of the film.

---

* President.

* President—April, 1952–1953.

Four general meetings were held during the year when interesting speakers talked.

The Civil Defense Committee has been engaged in an active program.

The Ways and Means Committee arranged a fashion show and card party in November.

The Medical Research Committee gave support to Baltimore County Auxiliary at Timonium Fair.

The committee on Legislation worked with the Ballot Battalion on Election day, aiding mothers to vote.

Hospitality Committee was busy throughout the year serving lunch at our general meetings and serving coffee and doughnuts to the Doctors at Baltimore City Medical Society meetings.

The final climax and high light of our year was the Medical Chirurgical Ball on the eve of the Annual Faculty Meeting, April 27, 1953.

WOMAN'S AUXILIARY TO THE FREDERICK COUNTY MEDICAL SOCIETY

MRS. P. S. LANSDALE*

The Woman's Auxiliary to the Frederick County Medical Society has held three meetings of the scheduled four for the fiscal year 1952–1953 (October through May) and to date has the following record:

Total number of members, twenty-six. This includes three new members.

Mrs. Forbes Burgess, Chairman of "Today's Health" reported a total of fifteen subscriptions since October, and Mrs. Russell Guest, Chairman of the National Bulletin, reported a total of eleven subscriptions this year.

Our main source of funds was the Fashion Show-Luncheon at the Francis Scott Key Hotel on December 10th from which we derived $235.00 profit. It was our privilege at this time to have as our guest our State President, Mrs. Charles H. Williams.

The expenditures include the purchase of a 21 inch Admiral television set (table model) for $255.00 which was presented to the Nurses' Home of the Frederick Memorial Hospital for their recreation room, a repair bill of $20.35 for the movie projector which is used in the classroom to further the education of the nurses, along with new films to be shown.

The Auxiliary also voted to increase the amount of the Society Award, given each year at graduation, from $10.00 to $25.00, to the student nurse having the highest theoretical average and record of distinguished all-round efficiency in nursing.

Mrs. Byron D. White, Chairman of Nurse Recruitment, reported that Miss Clements, Director of Nurses at Frederick Memorial Hospital, has a total number of fifteen signed and accepted applications for the new training class in September and that she hopes to have twenty-five by that time. Mrs. Clements and Mrs. White, together with Mrs. Frank Worthington who is also on the Nurse Recruitment Committee, have visited High schools throughout the county talking on the subject and showing the students through the Hospital and Nurses' Home and inviting them to teas.

---

* President.

WOMAN'S AUXILIARY TO THE MONTGOMERY COUNTY MEDICAL SOCIETY

MRS. J. M. BANKHEAD*

1. Regular Luncheon meetings held on first Tuesday of each month September through April, three members serving as hostesses.

2. Programs, each Committee Chairman had charge of one program, at which time she presented her project.

3. Membership; 35 members for this year, an increase of seven over the previous year—an average attendance of fifteen to eighteen.

4. Auxiliary members sponsored a "Get Acquainted" dance for the Doctors on the third Tuesday in October, with one hundred couples in attendance.

5. Name badges have been typed to identify the members of the County Society and a posting board is used to hold them when not in use.

6. Diabetic Detection Clinic—two Auxiliary members served on this Committee.

7. Nurse Recruitment Committee now in process of choosing a candidate for our nursing scholarship.

8. Question Box exhibit held at Montgomery County Hospital Supper in August 1952.

---

* President.

9. Doctors' Day observed by Auxiliary, members delivering two hundred red carnations to the Doctors in Montgomery County.
10. Today's Health—seven subscriptions.

WOMAN'S AUXILIARY TO THE PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

MRS. DAVID S. CLAYMAN*

This past year, the Auxiliary to the Prince George's County Medical Society, has endeavored to formulate a program to cover as many phases of Auxiliary work as possible. I am pleased to present the following summary of the year's work:

In September 1952 the Auxiliary celebrated its TENTH ANNIVERSARY with a luncheon held at the Prince George's Golf & Country Club. The guest speaker was Mrs. Charles Williams, our State President.

On October 1952, the County Fair was held at Upper Marlboro, the County Seat. At the Fair, the Auxiliary showed movies on NURSE RECRUITMENT, HOW TO CATCH A COLD, SEE YOUR DOCTOR EARLY, and several other films which were obtained from the American Medical Association in Chicago. These films were later shown in the Upper Marlboro High School with special emphasis on the movie for NURSE RECRUITMENT. The Auxiliary also had two large displays set up at the Fair, one on MATERNAL AND CHILD CARE, and the other on DANGERS OF SELF DIAGNOSIS AND SELF MEDICATION. These displays were manned at all times by members who distributed leaflets on subjects pertaining to HEALTH and to the various medical bills which were under discussion at the time.

Last year the Auxiliary gave a worthy girl in the County a scholarship to a school of nursing of her choice. This girl was selected on the basis of her scholastic ability and aptitude by examinations given by the SCHOOL BOARD. The Auxiliary voted to do the same thing this year. A THEATRE PARTY was held and a profit of $460.00 was made, out of which $300.00 will be used to take care of the scholarship.

In March of this year, the Medical Society and the Staff of Prince George's General Hospital were surprised to learn that an enterprising young delegate, a member of the County Delegation to the General Assembly, had written and was trying to put over a bill in Annapolis which would have placed the administration of the Hospital under direct political control. When the Medical Society, Hospital Guild and other interested groups heard of this bill, it was decided to protest against it. The Auxiliary sent letters to each Delegate and to the Senator of the County protesting the proposed bill. In addition, I went to Annapolis with the representatives of the Medical Society to attend the hearing upon the proposed bill. Upon hearing some of the delegates laughingly sneer and define the Auxiliary as "THE DOCTORS BOSSES AT HOME," I decided to speak up. I stated who made up the membership of the Auxiliary, what the Auxiliary had done for the hospital in the past, what it was doing for it at present and what it hoped to do for it in the future, then ended by voicing the protest of fifty active members against the bill. I would like to think that this helped even a little to defeat the proposed bill.

Phone calls were made to the members of the county delegation and to our Senator when we received word that the Bill on DOCTORS' DAY was due to come up for consideration. When we were notified that the bill was coming up definitely on March 30th, the Auxiliary sent telegrams to these same men urging the passage of the Measure.

On DOCTORS' DAY, The Prince George's General Hospital furnished a beautiful buffet luncheon for the doctors. The Auxiliary sent out the invitations, set up the tables, helped serve the luncheon and presented each doctor as he entered the hospital with a beautiful red carnation. In addition, I was interviewed by Mr. Ernie Tannen, the Program Director of Radio Station WGAY, Silver Spring, Md., on the subject of DOCTORS' DAY.

All of these endeavours received good notices from the press.

In addition we have had various programs throughout the year, such as a Musicale, a Book Review, afternoon of cards, etc. At Christmas time, the Auxiliary supplied groceries and clothing to a needy, local family. The Auxiliary paid for $100.00 worth of magazines and periodicals for the hospital. We subscribed to the BULLETIN and we took subscriptions to TODAY'S HEALTH, sending some to the schools.

---

* President, Selma H. Clayman (Mrs. David S. Clayman).

My sincere thanks to the Officers and the Committee Chairman for a most cooperative year, and to the individual members for their staunch, wholehearted support thereby contributing to an enjoyable and a successful year.

ANNUAL REPORT OF THE WOMAN'S AUXILIARY TO THE WASHINGTON COUNTY MEDICAL SOCIETY

MRS. GERALD W. LeVAN*

During the past year the Woman's Auxiliary to the Washington County Medical Society consisted of an active membership of fifty-eight out of an eligible sixty-five doctors' wives. Within the past months we gained five new members and our total membership today is sixty-three.

Nurse Recruitment is our one big project and we have awarded one (1) full scholarship in nursing and are prepared to grant partial scholarships to two girls (twin sisters) in the near future when they are accepted by the Nursing School. On March 24th, we will have a Tea for 200 high school girls, following their conducted tour of the Hospital and Nurses' Home, in our effort to increase their interest in nursing careers. Posters and pamphlets on nursing have been distributed in the offices of professional men, in the schools of the county, and in lunch rooms, Youth Centers, and wherever the students congregate. To add to our Nursing Scholarship Fund, we are holding an All-Day Rummage Sale on March 27th, and with each and every Auxiliary member contributing to this, we expect to make a rewarding addition to our treasury.

In September 1952, the Auxiliary manned a Health Booth during the week of the County Fair, at which time medical and health pamphlets were distributed and scientific exhibits shown. Our members assist in all health drives, such as Cancer, Polio, Red Cross, etc. Last fall, we sent more than 200 lbs. of medical supplies and literature to New York for overseas shipment.

At present we have 38 National Bulletin subscribers and 19 subscriptions to "Today's Health," and hope to increase these figures by the end of this year.

A chairman was appointed in January to work for the A.M.E.F.

With March 30th drawing near, we are deep in our plans for the annual observance of Doctors' Day when we will honor our doctors of Washington County.

---

* President.

* * * * *

FACULTY OFFICE AND LIBRARY HOURS

August—9 a.m. to 4 p.m.

Ancillary News

PHARMACY SECTION

MARYLAND PHARMACEUTICAL ASSOCIATION

L. M. KANTNER, PHAR. D.[1]

Journal Representative

A story is told, the veracity of which is not vouched for, but whether true or not, it does reveal the thinking of some people—likely a good proportion of the public relative to the procurement and use of a class of drugs that have been developed exclusively for use under medical supervision.

The story relates to Mrs. Blank who took her young child to a physician, telling him she wanted a "shot of penicillin" given the child for a cold. The physician's reply to the request was: "When did you begin directing your physician what medication to use? I will give the child an examination and if *I* consider penicillin is the proper medication, I will administer it. Otherwise, my judgment will dictate what treatment your child requires."

If this physician had the disposition alike to some people I know, under ordinary conditions, the child would not have gotten penicillin medication for the reason the physician would not have enriched Mrs. Blank's ego by allowing her to believe that after all "he did what I told him."

This story is related because of the number of people who have acquired a superficial knowledge of modern drugs through dramatic magazine articles, press releases written by enthusiastic writers, etc., and are quite willing to make guinea pigs of themselves.

Pharmacists report that many people make requests for drug products that can be dispensed only on prescriptions. Frequently, the request is amplified by "my doctor told me to get it." In many cases, the customer is untruthful by involving the physician; while at other times, they are truthfully carrying out a physician's instructions.

It would be ridiculous to claim all pharmacists are ethical in their professional or commercial conduct—they are as human as those in any vocation. There is a fringe who, regardless of consequences, will ignore any and all laws of decency and ethics. On the other hand, all are subject at times to being off guard, and a drug is supplied upon such requests as above mentioned by those whose professional conduct is unquestioned. However, under the law there is no immunity for the sale of what are termed dangerous drugs without a prescription.

The sale of such drugs as the barbiturates, amphetamine, sulfa drugs and thyroid by the unscrupulous often are not detected unless serious consequences occur from their unsupervised use. Often those who have suffered ill effects from the use of these drugs, particularly the barbiturates, will not divulge where they procured them because they evidently want to protect their suppliers, and to continue in good graces for future supplies.

For no other reason than for the public welfare have these drugs, by legislation, been taken out of reach except by physician's administration. No laws are entirely effective, nor do they successfully serve the purpose; but it is rational reasoning if there were not controls over the distribution of dangerous drugs, tragedies from their use would be comparable to their cures.

Reports are received that more and more physicians are including on their prescriptions authorization to refill a definite number of times, or signifying the prescription cannot be refilled. Adopting this policy obviates much annoyance to the physician, pharmacist, as well as the patient, when the latter desires a prescription refilled that requires the prescriber's authorization.

---

[1] Secretary, Maryland Board of Pharmacy.

POSTGRADUATE LECTURE COURSE IN BASIC SCIENCES TO BE OFFERED AGAIN IN 1953-54

DIETRICH C. SMITH, PH.D.*

For the third consecutive year, 1953–54, a course in THE BASIC SCIENCES AS THEY APPLY TO THE PRACTICE OF MEDICINE will be offered, according to an announcement by the Postgraduate Committee of the University of Maryland School of Medicine. The decision to repeat the course next fall was based on the response to a questionnaire sent to all those enrolled in 1952–53. When asked whether, in their opinions, the course should be repeated, all those who replied, unanimously recommended such action.

A considerable body of experience has now accumulated which will be valuable in formulating plans for the coming year. The questionnaires contained many helpful suggestions, all of which have been given serious consideration by the Committee and the lecturers responsible for the course. Special attention, however, is called to the fact that the course is concerned primarily with the fundamental biological concepts on which the practice of medicine rests and how these concepts apply to such practice. It is not intended to give specific instructions as to how to proceed in definite clinical situations. Such instruction is available at the numerous clinical pathological conferences, seminars, symposia, etc., sponsored by local hospitals and medical societies.

Judging from past experience, the course appeals to two groups of physicians; younger men who take it as part of the residency training program offered by their hospitals, and general practitioners who want to be brought up to date in the ideas that are germinating in the basic sciences. Particular stress will be laid on the changes which have occurred in this area within the last ten years or so. In this way, the course becomes a helpful review in the basic sciences for those men who are preparing for their board examinations.

Biochemistry, physiology, pharmacology, embryology, immunology, neuroanatomy, neurophysiology and histology are included, while gross anatomy and pathology are not. The latter two subjects are thoroughly covered in other courses in these special fields and offered by the University of Maryland School of Medicine. In the past, lecture schedules have included such subjects as the physiology of hypertension, its pharmacological and surgical control, natural and immune mechanisms of host resistance, practical aspects of neurophysiology and the pharmacology of the antibiotics and antihistaminics, to mention but a few.

Thirty-two two-hour meetings will be held, as in the past, on Wednesday at 4:00 P.M. except during University holidays, on the 2nd floor, Bressler Building, 29 S. Greene Street. The greater part of the enrollment usually consists of physicians in training in the Baltimore area, but any qualified and interested physician is welcome. Many local practitioners have taken advantage of this opportunity, and the course is open to the graduates of any approved medical school on application to the Committee.

The lecture schedule as well as the lecturers for the coming session will be announced shortly and may be obtained on request from the Office of the Postgraduate Committee, 6th floor Bressler Building, 29 S. Greene Street, Baltimore 1, Maryland. A detailed prospectus, further information and application blanks may be obtained from the same source. Telephone inquiries are also welcome. Call Mrs. Elizabeth Carroll, Plaza 2-1100, Extension 278. Tuition is $50.00 and is payable in advance. Registration will be held on September 21 and 22, 1953 from 9:00 A.M. to 4:00 P.M. at the Postgraduate Office, and the first lecture will be held on Wednesday, September 23, 1953.

Those who attend at least 27 of the regularly scheduled meetings shall be eligible, on vote of the Postgraduate Committee, to receive a certificate. Such certificates are issued on request to those regularly enrolled, on payment of an additional fee of $7.50 and on signing a statement that the required number of lectures have been attended.

---

* Vice-Chairman and Assistant Director, University of Maryland, School of Medicine Postgraduate Committee.

Maryland STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 2 *August, 1953* NUMBER 8

TRANSACTIONS

One Hundred Fifty-Fifth Annual Meeting

MEDICAL AND CHIRURGICAL FACULTY
of the State of Maryland
1211 Cathedral Street, Baltimore, Maryland

SCIENTIFIC SESSIONS
Tuesday and Wednesday, April 28, and 29, 1953

BUSINESS SESSIONS
April 27, 28, 29, 1953

ALSO
SEMIANNUAL MEETING, SEPTEMBER 12, 1952
BUSINESS AND SCIENTIFIC SESSIONS

For Completion of Transactions

The following papers, which were delivered at the Annual Meeting and are part of the 1953 Transactions, will be published in subsequent issues of the Journal: Presidential Address, Dr. Maurice C. Pincoffs, Harvey Grant Beck Memorial Lecture, Dr. T. S. Danowski, and I. Ridgeway Trimble Fund Lecture, Dr. J. S. L. Browne.

The Membership Roster, which is a part of the Transactions, was published in Volume II, No. 5, May 1953.

Scientific Sessions

BLEEDING ESOPHAGEAL VARICES AND THEIR SURGICAL TREATMENT[1]

ROBERT R. LINTON, M.D.[2]

Esophageal varices develop because of a state of portal venous hypertension which is caused by an obstruction to the outflow of the portal blood from the splanchnic area. The portal bed block may be 1) intrahepatic, due to cirrhosis of the liver, or 2) extrahepatic, secondary to thrombosis of the portal vein, seen most commonly in so-called Banti's syndrome, or 3) a combined type of intra and extrahepatic block secondary to cirrhosis of the liver and thrombosis of the portal vein. The esophageal varices are large venous collateral channels, through which some of the portal blood is shunted into the systemic venous system by way of the azygos and hemiazygos systems of veins. Unfortunately, these communications between the portal and systemic venous systems are not sufficiently large to shunt enough portal venous blood, so that a state of portal venous hypertension develops. As a result of this high portal venous pressure, many of the tributaries of the portal vein, including the submucous veins of the stomach, become greatly distended. These connect directly with the submucous plexus of veins in the esophagus through the cardio-esophageal junction. The appearance of them in the living is almost identical with large internal hemorrhoids of the anal canal. Esophageal varices, when present, are a constant and serious threat to a patient's life, since many individuals have succumbed due to exsanguinating hemorrhage from rupture of them. The cause of the rupture has never been satisfactorily explained. Even though the varices may extend the entire length of the esophagus, the point of rupture is invariably within a few centimeters of the cardio-esophageal junction. It seems not improbable that forceful contraction of the crus of the diaphragm, through which the esophagus passes, may in some way traumatize the mucosa, with resulting rupture of the varix.

The following statistics indicate the serious nature of this condition, and the threat to a patient's life that esophageal varices present, especially when they are secondary to cirrhosis of the liver. A recent analysis by Shull (23) of 128 patients, 108 with cirrhosis of the liver, and 20 with the so-called Banti's syndrome that were admitted to the Massachusetts General Hospital during the years 1934 to 1945 inclusive, because of bleeding esophageal varices, revealed that 97 or 76 per cent of the patients died from all causes. They were all treated conservatively except in a few instances when splenectomy was done for the so-called Banti's syndrome group. Death from exsanguination, secondary to rupture of the esophageal varices, was the cause of death in 46 or 47 per cent, and in many of the other 51 patients who died, bleeding from these vessels played a major contributory role. A further analysis of these statistics by Shull (23) revealed that in a group of 71 patients with cirrhosis of the liver and bleeding esophageal varices, 16 or 23 per cent had died at the end of one month, 29 or 41 per cent after six months, and 38 or 54 per cent at the end of one year; whereas, in 19 patients with the so-called Banti's syndrome only 1 or 5 per cent had succumbed at the end of one year. These figures demonstrate that the massive type of bleeding which occurs in these patients from the esophageal varices is much more serious in patients with cirrhosis of the liver than in the younger age group with Banti's syndrome. Shull also showed from his statistical study that the mortality rate after the diagnosis of esophageal varices had been made in the patients with cirrhosis of the liver, was 50 per cent at the end of one year, and after four years, 78 per cent of the patients had died. The life expectancy in patients with the so-called Banti's syndrome, on the other hand, was much better, since 90 per cent were alive at the end of one year and 70 per cent at the end of four years. He also found that the mortality risk of repeated hemorrhages was very grave in those patients with cirrhosis of the liver. In 66 cases, 11 or 17 per cent of them died following the first hemorrhage, whereas the mortality rate increased to 50 per cent in those who bled for the fourth time. The mortality risk was not nearly so great in 20 cases of Banti's syndrome, even though the patients had repeated hemorrhages. It was between 5 and 10 per cent. All these statistics demonstrate clearly the high mortality rate resulting from bleeding esophageal varices, especially in those patients with cirrhosis of the liver, and the importance of developing some form of treatment to prevent further bleeding from these vessels.

---

[1] John M. T. Finney Fund Lecture, Annual Meeting, Medical and Chirurgical Faculty of Maryland, Baltimore, Maryland, Tuesday evening, April 28, 1953.

[2] Assistant Clinical Professor of Surgery, Harvard Medical School, Visiting Surgeon and Chief of the Peripheral Vascular Clinic, Massachusetts General Hospital, Boston, Massachusetts.

Many surgical procedures have been performed and recommended for the treatment of bleeding esophageal varices. These include interruption of the splenic artery (3, 12), interruption of the hepatic, splenic and left gastric arteries (2, 20), and splenectomy. It was hoped by these procedures to reduce the arterial inflow to the splanchnic area and thereby reduce the portal venous pressure. Although this may occur, the reduction in the portal venous hypertension does not persist, so none of these procedures give lasting benefit; at best, it is only temporary. Two other procedures have been recommended in an attempt to develop a collateral circulation, namely, an omentopexy, the Talma-Morrison (10, 25) operation, and the packing of the superior mediastinum, as recommended by Garlock (24). They have proven to be of little or no benefit. Attempts have also been made to ligate the vessels which were thought to be feeding the esophageal varices, namely by a transabdominal route, suggested by Walters and Rowntree (27), or the transthoracic route, as suggested by Churchill and Sweet (7). Both of these procedures have proven of little or no value, since they interrupt the outflow of blood from the esophageal varices, rather than the inflow to them. A number of procedures have been recommended in which the esophageal varices are attacked directly. The first of these was by an attempt to obliterate them through the use of sclerosing solutions injected under direct vision by esophagoscopy (8, 18). This procedure, unfortunately, has not proved efficacious and has been given up in most clinics. Several surgeons have recommended either a total gastrectomy or an esophagogastrectomy (1, 18, 28) with the purpose of interrupting the large venous channels feeding the esophageal varices. These procedures, perhaps, are worthwhile as a last resort but are not the ideal solution, since they all entail a radical surgical approach and too frequently the patients are in such poor condition they cannot withstand these extensive surgical procedures. A method that has been used in our clinic, which has proved very efficacious as an emergency method of controlling the bleeding esophageal varices, consists of a transthoracic transesophageal suture of the esophageal varices and those in the fundus of the stomach (17). All of these methods are not definitive, in that they do not reduce permanently the portal hypertension, so that it is believed a more effective method must be utilized which will correct this abnormal state, and thereby prevent rupture of the esophageal varices.

The utilization of the by-pass operation by anastomosing some large vessel in the portal venous system, such as the splenic or portal vein, to the systemic venous system, has been found to reduce the portal venous pressure and to yield the most encouraging results in the control of the bleeding from esophageal varices of any method of treatment. Eck (11), in 1877, was the first to construct such a by-pass, or shunt operation, by anastomosing the portal vein to the inferior vena cava in experimental animals. Various attempts were made in the years thereafter to construct such an anastomosis in the human patient, but only two successful ones were recorded in the literature according to Whipple (29), until 1945, when Whipple and Blakemore (4) reported their encouraging results. Since then many successful shunt procedures have been performed in various clinics (5, 16), demonstrating the value of this method of treatment. There are few surgical procedures that are performed today which equal in magnitude the construction of a portacaval shunt, whether it be a splenectomy with a splenorenal anastomosis, or a direct portal vein-to-inferior vena cava type. In an occasional case the procedure will be relatively simple, but in the majority it is a long and tedious operation, which taxes both the surgeon and the patient. It is an operation that should never be done as an emergency procedure, because of its magnitude. For this reason the number of patients that it has been possible to perform these procedures upon have been limited to a great extent. As evidence of this, the following statistics were collected at the Massachusetts General Hospital, for the period from 1946 to 1950 inclusive. During this five-year period 99 patients were admitted to the Massachusetts General Hospital because of cirrhosis of the liver. In this group of patients portacaval shunts were performed in 33 or 33 per cent of them, and in 66 or 67 per cent, no surgical procedure was carried out. This was due in large part to the fact that 38 or 58 per cent of the latter group died while in the hospital, and of utmost importance is the fact that hemorrhage from the esophageal varices played a major role in the deaths of 32 or 84 per cent of these 38 patients. A further analysis revealed that exsanguination was the chief cause of death in 23, or 72 per cent of them, and in the other 9 or 28 per cent of the patients, death was due to liver failure; in 4 of them definitely brought on by massive hemorrhage. In the other 5 minor hemorrhage undoubtedly contributed to the liver failure. From these statistics it is obvious that in order to save the lives of many of these patients, it is necessary that an emergency method of controlling the bleeding esophageal varices at the time of acute hemorrhage should be developed.

EMERGENCY TREATMENT OF BLEEDING ESOPHAGEAL VARICES

None of the operative procedures that have been described above, except the direct suture of the bleeding esophageal varices through a transthoracic and transesophageal exposure, can be performed safely, because of the high mortality rate that the more major procedures carry, and the ineffectiveness of controlling the bleeding by the less radical ones. Because the hemorrhage is frequently so massive, and the patients are in shock on arrival at the hospital, due to the large loss of blood, it is necessary to use some method to temporarily control the bleeding in order to restore the circulating blood volume to normal by multiple transfusions so that this operative procedure can be safely performed. Temporary control of the bleeding vessels has been obtained, utilizing cardio-esophageal tamponade, as advocated by Rowntree et al. (21), and Sengestaken and Blakemore (22). Blakemore has recommended utilizing this method of control for prolonged periods, but in our experience the bleeding too frequently begins again after removing the tamponade. It is our rule now to proceed with the transesophageal suture of the esophageal varices if it is necessary to resort to cardio-esophageal tamponade to control the hemorrhage. Our method is to insert a two-lumen tube into the stomach with a balloon connected with one of the lumens, which can be inflated after placing it in the stomach. The balloon is then impinged at the cardio-esophageal junction by drawing the tube outward, and maintaining two pounds of traction on the end of it. It is possible in this way to control immediately, this severe type of hemorrhage, because the flow of blood into the esophageal veins is from the large submucous venous plexuses of the stomach. Even though the actual rupture site of the varix may be 4 to 5 centimeters above the cardio-esophageal junction, and is not pressed upon by the balloon, the bleeding can be controlled. The demonstration of a small opening about 1 to 2 millimeters in diameter in an esophageal varix that lay 5 or 6 centimeters above the cardio-esophageal junction, from which one of our patients died from exsanguination and who had been treated with the balloon tube on several occasions because of repeated hematemesis, and who never could be gotten into a satisfactory condition for a shunt procedure, was convincing evidence that a direct surgical attack on these bleeding varices at the time of hemorrhage might save such a patient's life.

Boerema (6) and Crile (9) have described this direct approach to the esophageal varices, but have recommended this procedure as a definitive operation, rather than one to control the bleeding at the time of hemorrhage. It seems doubtful that it will do this, since it in no way affects the state of portal hypertension. It is our opinion, however, that it is a lifesaving procedure at the time of acute hemorrhage. The patient is anesthetized with the balloon tube still in place, first by cocainizing the throat and larynx and then inserting a tracheal tube with an inflatable rubber cuff, which is distended to prevent aspiration of blood during the induction of the anesthesia, and also while the operation is being performed. The anesthetic of choice is cyclopropane in the patient with cirrhosis of the liver, although ether may also be used. The patient is placed in the right decubitus position, and the left pleural space opened by resecting subperiosteally the 7th rib. The lower end of the esophagus and the upper portion of the stomach are exposed, and a longitudinal incision about 5 or 6 centimeters in length is made, equally placed in these two structures. Tremendous dilated venous channels will be seen within the lumen of the esophagus, and not infrequently the actual site of rupture may be visualized. The method of controlling the bleeding varix and the other varices, is to pick them up with the mucosa covering them, and suture them with No. 00 chromic catgut on an intestinal atraumatic needle; an over-and-over running type of suture is used. The suturing is extended well down into, and including the gastric mucosa with its large submucosa veins, and then carrying it up the esophagus for a distance of 5 or 6 centimeters (17). As a rule it is possible to isolate three columns of varices and suture each in this manner. The incision in the esophagus is then closed transversely, using three layers of fine interrupted infolding type of silk sutures. Penicillin and streptomycin are administered intramuscularly, both before and after the operation. Primary healing of the esophageal incision has occurred in all cases, with no complications of empyema or serious infections. In view of the large amounts of blood lost prior to the operation it is necessary to have available multiple transfusions during the operative procedure.

During the past two and one half years this procedure has been performed on 15 patients. There has been one early postoperative death in the group, an operative mortality rate of approximately 6 per cent. In the remaining 14 patients there were three cases of Banti's syndrome, in whom a shunt could not be performed because their spleens had been previously removed. Attempts were made in each of these to isolate the portal vein but it was impossible because of the cavernomatous change surrounding it. The procedure was also performed in a fourth patient under these conditions, with cirrhosis of the liver. It has been possible to perform satisfactory portacaval shunts in 6 of the remaining patients, and in 2 others it is planned sometime within the near future. One patient died six weeks after the procedure from liver failure, not directly connected with the operative procedure. Another patient succumbed eight weeks later from massive esophageal bleeding, who had refused to have a shunt procedure performed at the usual period of four to six weeks after the suturing. Secondary hemorrhage has occurred in 6 patients within one to five months after the esophageal varices were sutured, and for that reason it is now our rule to perform the shunt operation at the end of three to four weeks, providing the patient's condition has improved sufficiently to warrant this major procedure. The great advantage of this method of controlling the bleeding esophageal varices is that once the bleeding is controlled the patient's condition can be built up more satisfactorily by proper food and vitamin intake than by any other method, and also their blood volume and hemoglobin restored to normal; so that the definitive procedure of a shunt can be performed under the most optimum conditions.

THE DEFINITIVE TREATMENT BY PORTACAVAL SHUNTS

The construction of a splenorenal, or a direct portal vein-to-inferior vena cava anastomosis, to by-pass the portal blood around the site of the portal bed block, whether it be intra or extrahepatic, is believed to be the most satisfactory method of controlling hemorrhage from esophageal varices. *It is to be emphasized that every patient who has bled from the esophageal varices, should be considered a candidate for some type of portacaval shunt, rather than any other operative procedure.* Since we have seen little if any improvement in the liver function tests following the construction of these shunts, the operation should not be done with the expectation that the liver function will necessarily improve. *At the same time it should be stressed that the construction of a portacaval shunt should never be done for the relief of chronic ascites alone.* In general there are three groups of patients with bleeding esophageal varices who are suitable for this type of surgery; 1) those with portal cirrhosis without ascites, 2) those with portal cirrhosis and ascites that responds to medical therapy, and 3) any patient with so-called Banti's syndrome, or extrahepatic portal bed block. One of the greatest challenges to the surgeon is the operative treatment of patients with chronic ascites, secondary to cirrhosis of the liver, and in addition with bleeding esophageal varices. The operative mortality rate in this group of patients is so great it is believed unwise to attempt to do shunt surgery on them. For that reason it is believed the best treatment for such a patient is a preliminary esophagotomy, with suturing of the esophageal varices, with the hope that by medical means it will be possible to improve the patient sufficiently to clear the ascites. This has been accomplished in several cases, so that it has been possible to perform a shunt procedure at a greatly reduced risk.

Liver function tests are obtained on all patients in whom portacaval shunt surgery is planned (15). It is possible by these, as a rule, to differentiate between the intrahepatic and extrahepatic type of portal bed block, since in the former there are abnormalities in many of the tests, whereas in the latter they are essentially normal. In addition, it is important to determine how seriously the liver is damaged before doing the actual shunt surgery. The following tests, in our opinion, are of the most value in determining the operability of patients with cirrhosis of the liver: 1) The serum albumin level is probably one of the most significant, especially if the level is below three grams per cent, since in 6 patients with a level below this figure, there were 5 deaths, or a mortality rate of 83 per cent; whereas, in those patients with a level above 3 grams per cent, there were 69 patients, and 6 deaths, a mortality rate of 9 per cent. 2) The presence of ascites is also considered to be a test of liver function, indicating failure of the liver to synthesize the normal levels of serum proteins. If the ascites fails to respond to medical therapy it is a serious omen, whereas, if it does respond, or is not present, the patient is considered a much better operative risk. 3) If the prothrombin time is prolonged, and especially if it does not respond to vitamin K therapy, it, as a rule, indicates severe liver disease. 4) The cephalin flocculation test, if it is 3 or 4 plus, indicates that the patient is a serious risk, since in 36 operations with these values there were 11 deaths, or a mortality rate of 31 per cent; whereas in 39 patients with 1 or 2 plus cephalin flocculation, there were no deaths. 5) The bromsulfalein retention test, a measure of the excretory function of the liver, is of less significance unless the degree of retention is very high. A level of 20 per cent or more of retention indicates a severe liver injury, and further medical treatment is recommended to attempt to improve it. 6) The bilirubin level in the blood, as measured by the van den Bergh test, is of significance if there is moderate to severe degree of jaundice, since it indicates serious liver disease.

TYPES OF PORTACAVAL SHUNTS

For practical purposes there are two main types of portacaval shunts which have proved most efficacious in controlling the bleeding from the esophageal varices. These are 1) an end-to-side splenorenal anastomosis with splenectomy, and 2) a direct portal vein-to-inferior vena cava anastomosis. The splenorenal type of shunt has been performed more frequently in our clinic. In the eight-year period from 1945 to 1952, 90 portacaval shunts have been performed, and of these 68 or 75 per cent, have been the splenorenal type, whereas, 22 or 25 per cent have been the direct portacaval (Table I). It is believed in the majority of cases that the former is the safer operation, since there is less danger of damaging such structures as the hepatic artery, or the common bile duct, which lie in such close proximity to the portal vein. Many surgeons prefer the direct portal vein-to-vena cava type of anastomosis because the splenic vein is so thin-walled and friable, which makes it difficult to isolate. In our own hands, however, the mortality rate in recent years has been less with this type, because it seems to interfere less with the liver function in the immediate postoperative period. In the last 42 patients with cirrhosis of the liver, in whom shunts have been performed, 27 patients had splenorenal anastomoses, with 1 death, or a mortality rate of 4 per cent; whereas, in the direct portacaval anastomoses there were 15 with 2 deaths, or an immediate postoperative mortality rate of 13 per cent. The death in the former group was secondary to sepsis, whereas the latter 2 were the result of liver failure. In addition to this difficulty there were 2 patients who had direct portacaval shunts, that developed severe and incapacitating ascites lasting for months, a condition that has not been seen to develop after the splenorenal type of shunt. The decision of whether to do a direct portacaval or a splenorenal anastomosis usually is determined by the size of the spleen, and also the condition of the patient, and the degree of liver impairment. If the spleen is greatly enlarged it has been found, as a rule, that the splenic vein is correspondingly large and can be used to construct a very satisfactory shunt; whereas, if the spleen is small, both by palpation and x-ray examination, the splenic vein frequently is too small to make a satisfactory shunt. Under these conditions, if the liver function is not too seriously impaired, a direct portacaval anastomosis is usually attempted.

TABLE I

Types of Portacaval Shunts

Massachusetts General Hospital 1945–1952 (Inclusive)

Splenorenal	68	72%
Direct portacaval	22	24%
Others	4	4%
Total	94	100%

In patients with the so-called Banti's syndrome, or the extrahepatic type of block, the operation of choice is without question the splenorenal shunt, because in most of these patients the portal vein is impossible to isolate because of a cavernomatous change surrounding it in the gastrohepatic ligament. The method of performing the splenorenal shunt is preferably by an end-to-side type of anastomosis, implanting the end of the splenic vein into the side of the renal vein. In this way it is possible to preserve the kidney, as was first described by the author (15) in 1947. Unfortunately, with this type of anastomosis in our group of patients, there has been a greater incidence of postshunt esophageal bleeding than in the patients with direct portacaval shunts. These statistics are given in the summary of the results.

One advantage of the direct portacaval type of anastomosis, is that when it can be performed it is a relatively easier operation for the surgeon. Unfortunately, this may not be true for the patient, since as already stated, there is evidence accumulating to indicate that this type of shunt may produce more serious effects on the liver than the splenorenal type. There are two methods of anastomosing the portal vein and the inferior vena cava; 1) it may be a side-to-side anastomosis, without interrupting the continuity of the portal vein, or 2) an end-to-side anastomosis, implanting the distal end of the portal vein, after dividing it, into the inferior vena cava. In most instances the latter is the more feasible procedure, and it is believed probably in the majority of instances to be the better shunt. It has been criticized because it by-passes completely the liver of all the portal venous blood. But actually, since in some of the patients there is a high degree of intrahepatic portal bed block, this may not be as great as one would assume. At the present time it is thought that where there is a high degree of intrahapatic block, that the side-to-side anastomosis should not be used, because with this type of shunt not only is the portal venous blood shunted from the liver, but also that from the hepatic artery as well, since it enters the portal venous system in the presinusoidal areas and will follow the path of least resistance, which will be to pass directly into the inferior vena cava through the direct portacaval shunt. As a result a great deal of the liver will be deprived of the arterial blood as well as the portal venous blood. With the splenorenal shunt apparently this difficulty is not so marked, probably because the shunt is less complete.

At the present time, it is believed that those patients with an intrahepatic block, secondary to cirrhosis of the liver, in whom the liver function is not too seriously impaired, are the most suitable candidates for direct portacaval shunts. Thrombosis of the portal vein itself will be encountered in some instances of cirrhosis of the liver, and in 3 patients it has been necessary to perform a thrombectomy in order to obtain a flow of blood through the portal in order to construct a shunt. In 2, very satisfactory shunts were obtained, but in the other it apparently has not functioned too well, since secondary bleeding has occurred on one occasion. It is the only instance of secondary bleeding in a group of 15 direct portacaval shunts in patients with cirrhosis of the liver. For this reason it is believed, therefore, that the direct portal vein-to-inferior vena cava shunt is probably the best operative procedure to control the esophageal bleeding, but unfortunately it cannot be performed on all patients, and in others, because of severe liver disease, it should not be performed. At the present time, however, if a patient has a large spleen, even with good liver function, we believe it safer to do the splenorenal shunt and if bleeding should recur, then resort to the direct portacaval anastomosis.

ANESTHESIA

It is believed that the type of anesthesia plays an important part in the mortality rate of these major surgical procedures. Early in the course of our experience ether anesthesia was used routinely and in many instances a hemorrhagic diathesis developed during the operative procedure. Because of this complication a high percentage of our early deaths in the immediate postoperative period was from uncontrollable hemorrhage from the operative field. As a result of these experiences ether anesthesia was abandoned in favor of cyclopropane anesthesia, which seemed to have a less damaging effect on the seriously sick liver, with a result that deaths from operative hemorrhage became much less common. This was also aided, in part, by the use of fresh blood transfusions during the operation, as recommended by Soutter (25). Nevertheless it was necessary to utilize from five to ten blood transfusions during each operative procedure. During the past year hypotensive spinal anesthesia, given according to the Gillies technique (13, 14), has been utilized in 17 shunt operations. There have been no complications from this method of anesthesia and no deaths from hemorrhage; furthermore there has been a great saving of bank blood, since in most instances, one or two transfusions have been utilized, and never more than three. Studies are not fully completed as yet, but there appears to be less interference with liver and renal functions, than when the other types of anesthesia are used, with which so many transfusions of citrated blood are required. Further experience is necessary, however, before one can be absolutely sure this is the anesthesia of choice.

Summary of Results in 94 Shunt Operations in 90 Patients with Bleeding Esophageal Varices

The construction of some type of portacaval shunt has been the method of treatment for bleeding esophageal varices at the Massachusetts General Hospital since 1945. Ninety patients have had shunts performed up to January 1, 1953. The results obtained in this group of patients have been extremely encouraging, as the following statistical analysis shows. There were 24 or 27 per cent of them with an extrahepatic portal bed block, secondary to the so-called Banti's syndrome, and 66 or 73 per cent with an intrahepatic block secondary to the portal cirrhosis of the liver. In the entire group there were 30 females, or 33 per cent, and 60 males, or 67 per cent. Separated in types of disease there were 9 females with the extrahepatic type of portal bed block, or 27 per cent, and 15, or 63 per cent were males; while in the patients with cirrhosis of the liver there were 21, or 32 per cent, females, and 45, or 68 per cent males. Their ages ranged from the youngest of six years to the oldest of 70 years. The disease is apparently most common in mid life, since 64 or 70 per cent of them were between 30 and 60 years of age. A total of 94 shunts were performed in these 90 patients, since in 4 patients, 3 with splenorenal anastomoses, and 1 with an inferior mesenteric vein-to-left ovarian vein, who had secondary hemorrhages, direct portacaval anastomoses were performed at later dates. There were 68 end-to-side splenorenal shunts with splenectomy, or 72 per cent; 22, or 23 per cent, had direct anastomoses between the portal vein and the inferior vena cava. Eighteen of these were end-to-side and 4 were side-to-side. Four other patients, or 5 per cent, had other types of shunts, including an anastomosis between the superior mesenteric vein and the inferior vena cava, and an inferior mesenteric vein anastomosis between the left ovarian in one case, and in another to the left adrenal vein (Table I). This latter group of four shunts are what might be termed makeshift shunts because they were done since it was impossible to perform a splenorenal shunt because the spleen had been previously removed, and a cavernomatous change around the portal vein made it possible to isolate this blood vessel. Because of the poor results obtained, these shunts are no longer attempted in our clinic. In the 24 patients with the extrahepatic portal bed block, 25 shunts were performed; 19, or 76 per cent, were end-to-side splenorenal anastomoses, 3 or 12 per cent, had direct portacaval anastomoses, and 3 or 12 per cent, had the other types. The greater preponderance of the splenorenal shunts in this type of disease is because of the cavernomatous transformation of the gastrohepatic ligament, which makes it usually impossible to isolate the portal vein, so that a direct portacaval shunt cannot be performed.

There were 66 patients with cirrhosis of the liver with an intrahepatic portal bed block, in whom 69 shunts were performed. Forty-nine, or 71 per cent, were end-to-side splenorenal shunts; 19, or 27 per cent, were direct portacaval anastomoses, and in one other a superior mesenteric vein-to-inferior vena cava shunt was performed. There were more direct portacaval shunts done in this group than in the Banti cases, since exposure of the portal vein in this disease is more readily accomplished, and it was felt necessary to determine, if possible, whether the splenorenal or the direct portacaval shunt was superior to the other from the viewpoint of postshunt bleeding, and also what effect each procedure might have on the liver function in addition to their respective mortality rates. At the present time it is believed that the operative risk is less for the splenorenal shunt, since most of our deaths from liver failure and hemorrhage have followed direct portacaval anastomoses. There is no question, however, but that the latter type reduces the portal hypertension more effectively, and therefore gives better protection against further esophageal bleeding. It is also an easier shunt to construct, providing the cavernomatous change in the gastrohepatic ligament is not encountered. Further studies are in progress to determine, if possible, if there is any difference between the two types of shunt in regard to liver function in the survival patients. To date it has been a disappointment that there has been little of any improvement in the liver function tests following either splenorenal or direct portacaval anastomoses, even though no further bleeding episodes have occurred.

An analysis of our results reveal that 77 or 86 per cent of the patients, survived, giving an operative mortality rate of 14 per cent. It is of considerable significance that the majority of the postoperative deaths occurred in the earlier years that this type of surgery was being performed, since during the last three and one half years there have been no deaths from immediate postoperative hemorrhage, and only 3 deaths in the last 60 shunts performed, or an operative mortality rate of 5 per cent. Two of the deaths were from liver failure following direct portacaval anastomoses, and the third was from pancreatic necrosis and sepsis following a splenorenal shunt. This reduction in the mortality rate, it is believed, is the result of a more careful preparation of the patients with sick livers, the elimination of the hemorrhagic diathesis occurring during the operative procedure, first by utilizing fresh blood transfusions during the operative procedure, and also the use of cyclopropane anesthesia instead of ether; and lately the use of hypotensive spinal anesthesia, which eliminates almost completely any danger of severe hemorrhage during the operation. Finally, of course, the perfection in the technique in this type of surgery, without question, has been a factor in the lower mortality rate in the recent years. As might be expected the immediate postoperative mortality is much greater in patients with cirrhosis of the liver than in those with the so-called Banti's syndrome with essentially normal livers. There were 69 shunts in the intrahepatic or cirrhotic group, with 6 deaths from early postoperative hemorrhage from the operative field, 4 from liver failure, 2 from sepsis; a total of 12 deaths, or an operative mortality of 17.4 per cent; whereas, there were 25 shunts performed in the extrahepatic group, with 1 death from postoperative hemorrhage, or an operative mortality rate of 4 per cent.

An analysis of the patients in whom esophageal bleeding has recurred following the shunt procedures (Table II), in 60 patients who had splenorenal shunts, revealed there have been 3, or 5 per cent of the cases, that developed minor bleeding not requiring hospitalization. In 5 cases, or 8 per cent, major bleeding has developed; in 4 of these patients secondary direct portacaval anastomoses have been performed with relief of bleeding in 2 of these patients. There has been one death in this group from massive bleeding from the esophageal varices, an incidence of 1.7 per cent. In 18 patients with direct portacaval anastomoses there were no incidences of minor bleeding; there were 2 patients who had major bleeding and in one of these it had been necessary to do a thrombectomy of the portal vein in order to clear it of a thrombus so that anastomosis could be performed. It is feared that another thrombus probably formed, since the intima of the vein was very ragged after removing the clot.

TABLE II

Summary of Esophageal Bleeding following 78 Survival Shunt Operations

Massachusetts General Hospital 1945–1952 (Inclusive)

TYPE OF SHUNT	NO. OF SHUNTS	POSTSHUNT BLEEDING		
		Minor	Major	Deaths from bleeding
Splenorenal	60 (80%)	3 (5%)	5* (8%)	1 (1.7%)
Portacaval	18 (20%)	0	2† (11%)	0
Totals	78 (100%)	3 (4%)	7 (9%)	1 (1.3%)

* 4 of these patients had secondary portacaval shunts with relief of bleeding in 2.

† 1 of these patients had a thrombosed portal vein.

There have been no deaths from bleeding following any of the direct portacaval shunts. In summary then, following 78 survival shunt operations, there have been 3 cases of minor bleeding, or an incidence of 4 per cent; 7 cases of major bleeding, or 9 per cent; and one death, or an incidence of 1.3 per cent.

A further analysis of our results reveals that in 23 patients with extrahepatic portal bed block, secondary to the so-called Banti's syndrome, who survived the construction of a splenorenal or a portacaval shunt, there has been one death in the follow-up period from 1945 to 1952 (Table III), inclusive. The death in this case occurred four years after a splenorenal shunt was performed and was unrelated to the portal hypertension, since it occurred as the result of a cerebral hemorrhage. In the group of patients with intrahepatic portal bed block, secondary to cirrhosis of the

TABLE III

Late Deaths following Splenorenal and Portacaval Shunts in 77 Survival Patients

Massachusetts General Hospital 1945–1952 (Inclusive)

TYPE OF BLOCK	NO. OF PATIENTS	NO. OF DEATHS	CAUSES OF DEATHS			
			Liver failure	Heart failure	Cerebral hemorrhage	Esophageal hemorrhage
Extrahepatic (Banti's disease)	23 (29%)	1 (4.3%)	0	0	1 (4 yrs.)	0
Intrahepatic (cirrhosis)	54 (71%)	7 (13%)	4 (8, 20, 23, 43 mos.)	1 (5 mos.)	1 (19 mos.)	1 (12 mos.)
Totals	75 (100%)	8 (10.7%)	4	1	2	1

TABLE IV

End Results of Portacaval Shunts in 90 Patients with Bleeding Esophageal Varices

Massachusetts General Hospital 1945–1952 (Inclusive)

TYPE OF PORTAL BED BLOCK	NO. OF PATIENTS	POSTOPERATIVE DEATHS*	LATE POSTSHUNT DEATHS†	TOTAL SURVIVALS	EXPECTED SURVIVAL RATE WITHOUT SHUNT
Extrahepatic (Banti's syndrome)	24 (27%)	1 (4%)	1 (4.3%)	92%	70%
Intrahepatic (cirrhosis of liver)	66 (73%)	12 (18%)	7 (13%)	71%	20%
Totals	90 (100%)	13 (14%)	8 (10%)	77%	

* There have been only 3 postoperative deaths in the last 60 shunts performed, or a mortality rate of 5 per cent.

† Three of these deaths were unrelated to the esophageal varices or cirrhosis of the liver.

liver, there were 54 patients who survived the construction of splenorenal or portacaval shunts, and in this group 7, or 13 per cent, have died from various causes; 4 from liver failure respectively at 8, 20, 23 and 43 months after the shunts were performed, 1 from heart failure five months following the shunt, another from cerebral hemorrhage 19 months after it was performed. One patient succumbed to massive esophageal hemorrhage twelve months after a splenorenal shunt. In summary there are 77 patients that have survived the construction of portacaval shunts; 8 of these patients, or 10.7 per cent, are dead, and the remaining 69, or 90 per cent, are still alive, and for the most part in good health (Table IV). These results are a great improvement over the expected mortality rate in a similar group of patients followed over a period of the same number of years, since Shull (23) showed that in our hospital, the mortality rate for patients with Banti's syndrome was about 10 to 30 per cent, and in the patients with cirrhosis of the liver the expected mortality rate ranges from 50 to 80 per cent, for periods of one to five years.

Conclusions

1) Exsanguination from bleeding esophageal varices is a frequent cause of death in patients with cirrhosis of the liver and so-called Banti's syndrome.

2) Cardio-esophageal tamponade with an intragastric balloon tube, supplemented immediately by a transesophageal suture of the varices, is recommended as the best emergency method of controlling the massive bleeding in these patients when it does not stop spontaneously.

3) The by-passing of the portal venous blood in patients with bleeding esophageal varices, by the construction of a splenorenal or a direct portacaval shunt, is considered the best definitive method of treatment.

4) In the majority of patients a splenectomy, with an end-to-side splenorenal anastomosis is the preferable procedure, since it carries less risk than a direct portacaval shunt, especially in patients with severely diseased livers. It is also recommended in those patients with so-called Banti's syndrome, because of the difficulty in exposing the portal vein in them, due to the cavernomatous change in the gastrohepatic ligament.

5) Portacaval shunts are not to be recommended for the treatment of ascites alone; they should be reserved for the treatment of bleeding esophageal varices.

6) A surgeon should not perform a splenectomy alone in a patient with bleeding esophageal varices, unless he is prepared to do a splenorenal anastomosis at the same operation, since this may be the only opportunity to construct a satisfactory shunt, especially in patients with the so-called Banti's syndrome.

BIBLIOGRAPHY

1. Baronofsky, I. D.: Portal Hypertension; with Special Reference to Acid-peptic Factor in Causation of Hemorrhage and Extensive Gastric Resection in Its Treatment. Surgery, **25:** 135, 1949.
2. Berman, Jacob K. and Hull, James E.: Hepatic, Splenic and Left Gastric Arterial Ligations in Advanced Portal Cirrhosis. Arch. Surg. **65**, pp. 37–64, July 1952.
3. Blain, A. W. and Blain, A. III: Ligation of Splenic Artery, Operation of Choice in Selected Cases of Portal Hypertension and Banti's Syndrome. Ann. Surg. **131:** 92, 1950.
4. Blakemore, A. H. and Lord, J. W., Jr.: Technic of Using Vitallium Tubes in Establishing Portacaval Shunts for Portal Hypertension. Ann. Surg. **122:** 476, 1945.
5. Blakemore, A. H.: The Portacaval Shunt for Portal Hypertension with Special Reference to Cirrhosis of the Liver. Bull. N. Y. Acad. Med. **27:** 477, 1952.
6. Boerema, I.: Chirurgische Hulp By Bloedingen Uit Varices van den Oesophagus By Lever Cirrhose en By Het Syndrom van Banti. Arch. Chir. Neerl. **1:** 4174, 1949.
7. Churchill, E. D. and Sweet, R. H.: Personal Communication.
8. Crafoord, C. and Frenchner, P.: New Surgical Treatment of Varicose Veins of the Oesophagus. Acta. Otolaryng. **27:** 422, 1939.
9. Crile, G., Jr.: Transesophageal Ligation of Bleeding Esophageal Varices. Arch. Surg. **61:** 654, 1950.
10. Drummond, D. and Morison, R.: A Case of Ascites Due to Cirrhosis of the Liver Cured by Operation. Brit. M. J. **2:** 728, 1896.
11. Eck, N. V.: Ligature of Portal Vein. Voyemo-Med. J. **130:** 1, 1877.
12. Everson, T. C. and Cole, W. H.: Ligation of the Splenic

Artery in Patients with Portal Hypertension. Arch. Surg. **56:** 153, 1948.

13. Gillies, J.: Anesthesia for the Surgical Treatment of Hypertension. Proc. Roy. Soc. Med. **42:** 295, 1949.
14. Greene, N. M.: Hypotensive Spinal Anesthesia. Surg. Gynec. & Obst. **95:** 331, 1952.
15. Linton, R. R., Jones, C. M., and Volweiler, W.: Portal Hypertension: Treatment by Splenectomy and Splenorenal Anastomosis with Preservation of Kidney. Sur. Clin. North America **27:** 1162–1170, 1947.
16. Linton, R. R.: The Selection of Patients for Portacaval Shunts with a Summary of Results in 61 Cases. Ann. Surg. **134:** 433, 1951.
17. Linton, R. R. and Warren, R.: The Emergency Treatment of Massive Bleeding from Esophageal Varices. Transesophageal Suture of these Vessels at the Time of Acute Hemorrhage. Surg. **33:** 243, 1953.
18. Moersch, J. J.: Treatment of Esophageal Varices by Injection of a Sclerosing Solution. J.A.M.A. **135:** 754, 1947.
19. Phemister, D. B. and Humphreys, E. M.: Gastroesophageal Resection and Total Gastrectomy in Treatment of Bleeding Varicose Veins in Banti's Syndrome. Ann. Surg. **126:** 397, 1947.
20. Rienhoff, W. F., Jr.: Ligation of the Hepatic and Splenic Arteries in the Treatment of Portal Hypertension with a Report of Six Cases. Bull. Johns Hopkins Hospital: Vol. 88, No. 4, pp. 368–375, April, 1951.
21. Rowntree, L., Zimmerman, E. F., Todd, M. A. and Ajac, J.: Intraesophageal Varicose Tamponage. J.A.M.A. **135:** 630, 1947.
22. Sengstaken, R. W. and Blakemore, A. H.: Balloon Tamponage for the Control of Hemorrhage from Esophageal Varices. Ann. Surg. **131:** 781, 1950.
23. Shull, H. J.: Personal Communication of Unpublished Data.
24. Som, M. L., and Garlock, J. H.: New Approach to Treatment of Esophageal Varices. J.A.M.A. **135:** 628, 1947.
25. Soutter, L.: Personal Communication.
26. Talma, S.: Chirurgische Offnung Neuer Seitenbahnen fur das Blut der Vena Porta. Berlin klin. Wchnschr. **35:** 833, 1898.
27. Walters, W., Rowntree, L. G., and McIndoe, A. H.: Ligation of the Coronary Veins for Bleeding Esophageal Varices. Proc. Staff Meet., Mayo Clin., **4:** 146, 1929.
28. Wangensteen, O. H.: The Ulcer Problem. Seventh Listerian Oration. Canad. M. A. J. **53:** 309, 1945.
29. Whipple, A. D.: Problem of Portal Hypertension in Relation to Hepatosplenopathies. Ann. Surg. **122:** 449, 1945.

HOLD THIS DATE!

SEMIANNUAL MEETING—TUESDAY, OCTOBER 6, 1953

NATIONAL INSTITUTES OF HEALTH, BETHESDA, MARYLAND

Celebrating the fiftieth anniversary of the
Montgomery County Medical Society

Guest Speaker—Dr. Leonard A. Scheele, Surgeon General, Department of Health Education and Welfare of the U. S. Public Health Service

Business Sessions

SEMIANNUAL MEETING

Friday, September 12, 1952

Beach Lounge, Commander Hotel, Ocean City, Maryland

House of Delegates
Beach Lounge, Commander Hotel
Ocean City, Maryland
Friday, September 12, 1952

The 202nd meeting of the House of Delegates was called to order by the President, Dr. Alan M. Chesney, at 9:45 a.m. in the Beach Lounge of the Commander Hotel, Ocean City, Maryland, on Friday, September 12, 1952.

The roll call was by registration and the following were present: Doctors Conrad Acton, J. T. B. Ambler, David H. Andrew, E. Cowles Andrus, Charles R. Austrian, Cecil H. Bagley, Jacob W. Bird, Helen Bowie, M. McKendree Boyer, Webster H. Brown, Read N. Calvert, Robert V. Campbell, T. Nelson Carey, F. A. Camalier, Ferdinand E. Chatard, IV, J. Albert Chatard, Alan M. Chesney, Osborne D. Christensen, T. A. Christensen, John Newell Classen, Richard G. Coblentz, Melvin B. Davis, Newland E. Day, Everett S. Diggs, Richard C. Dodson, George O. Eaton, C. Reid Edwards, Monte Edwards, Wolcott L. Etienne, Houston S. Everett, Robert W. Farr, John S. Fenby, Whitmer B. Firor, John H. Griffin, Lewis P. Gundry, Donald Hooker, William B. Long, W. Kenneth Mansfield, James T. Marsh, Walter S. Niblett, John W. Parsons, Daniel J. Pessagno, Maurice C. Pincoffs, Francis J. Townsend, Jr., Ralph P. Truitt, Bernard J. Cohen and Ross Z. Pierpont.

On motion of Dr. Thomas C. Christensen, which was seconded and carried, the minutes of the previous meeting were not read by the Secretary as they had been mailed to all delegates and also were printed in the August issue of the Maryland State Medical Journal.

Dr. C. R. Edwards, Chairman of the Council, presented a report (see page 414) on the result of the approval of the component societies of the changes in income level and professional fees in Maryland Hospital Service, Inc.-Maryland Medical Service, Inc.

Dr. Winford H. Smith was unanimously approved for emeritus membership.

Dr. Walter D. Wise presented the report of the Advisory Committee to the State Department of Health. (See page 414). This report was unanimously adopted upon motion of Dr. Thomas C. Christensen and seconded by Dr. Ross Z. Pierpont.

Dr. J. W. Bird, Chairman of the Resolutions Committee presented resolutions which had been previously considered by the Resolutions Committee (see page 417), which consisted of Doctors J. W. Bird, Chairman, Charles R. Austrian, Robert V. Campbell, T. Nelson Carey, and William D. Noble.

Three resolutions presented by the Baltimore County Medical Association were as follows:

"*1.(a) BE IT RESOLVED that the Baltimore County Medical Association recommends that the members of the Council of the Medical and Chirurgical Faculty of the State of Maryland be limited to two (2) consecutive terms.*"

Dr. Bird stated the Committee approved this resolution and he moved that it be adopted.

Dr. Webster H. Brown moved that the word "elected" be inserted before "members of the Council" and Dr. Melvin B. Davis, delegate from Baltimore County Medical Association, said that the Society would accept the amendment. Dr. Thomas Christensen moved that the resolution as amended be adopted, seconded by Dr. Maurice C. Pincoffs and carried.

"*1.(b) BE IT RESOLVED that the President of the Medical and Chirurgical Faculty should be alternated each year between the Baltimore City Medical Society and the county organizations.*"

Dr. Bird stated that the report of the Resolutions Committee was unfavorable and moved that the House of Delegates adopt the report of the Committee. Seconded by Dr. Christensen. Dr. Davis of Baltimore County asked that the Resolutions Committee be overruled. Before this resolution was acted upon there was a considerable amount of discussion. The Baltimore County Medical Association had submitted this resolution hoping that there would be a greater participation by County members in Faculty affairs. However, it was pointed out that any such fixed rule might prove to be detrimental. Subsequent action of the House of Delegates supported the unfavorable recommendation of the Resolutions Committee.

"*1.(c) BE IT RESOLVED that the Nominating Committee for the officers of the Medical and Chirurgical Faculty of the State of Maryland be elected from the floor of the House of Delegates.*"

After reading the resolution Dr. Bird stated that the Committee report was unfavorable. He moved that the report of the Committee on Resolutions be adopted. Seconded by Dr. Christensen. This resolution evoked prolonged discussion. After the discussion, the House of Delegates sustained the unfavorable report of the Resolutions Committee.

A resolution sponsored by Dr. Mark V. Ziegler and Dr. Page C. Jett with reference to the Medical Care Program was presented. This resolution follows:

"*Whereas, The Medical Care Program was historically based upon a request of the Medical and Chirurgical Faculty* *and was unanimously approved by the Faculty before being enacted into law, and*

"Whereas, the principles of the program and its operation are basically satisfactory to the medical profession, and

"Whereas, the program has often been compelled because of inadequate appropriation to reduce the scope of services, the number of beneficiaries, or to pay only part of its just obligations from time to time, therefore be it

"Resolved, that the Medical and Chirurgical Faculty of Maryland endorses the principles and operations of the aforementioned program and recommends that sufficient funds be appropriated to efficiently carry out the program as now constituted; and be it further

"Resolved, that the Secretary of the Medical and Chirurgical Faculty be instructed to send a copy of these resolutions to the Governor of Maryland; to the respective members of the Senate Finance Committee, and the House Ways and Means Committee of the General Assembly; to the Director of the Maryland State Health Department, and to the Commissioner of Health of Baltimore City, and Budget Director of the State of Maryland."

The Committee on Resolutions recommended its adoption. This resolution also evoked considerable discussion. It was the consensus of opinion that the Society would do credit to reaffirm its belief in the principles in the Medical Care Program. Upon motion by Dr. Andrus, seconded by Dr. Marsh, the recommendation of the Resolutions Committee for approval was unanimously sustained. (See page 418 for the report which Dr. Ziegler made to the House of Delegates.)

A resolution submitted by Dr. Amos R. Koontz with reference to the Presidential appointments on committees was presented as follows:

"There has always been the complaint that our Medical Society is run by a few people. That is probably because in any Society there are only a few people who are willing to do the work. There are always drones and always workers in every group. The drones cannot be gotten to work no matter how much responsibility is thrust upon them. However, to stimulate more interest and to secure more active participation by all members of our Society in the affairs of the Society.

"BE IT RESOLVED, that it is the desire of the House of Delegates that each new President, in appointing his committees, appoint not more than half of those who served on each committee the year before, and that in no instance shall a man serve on any committee longer than three consecutive years."

Dr. Bird stated that the Resolutions Committee submits an unfavorable report and he moved that the report of the Committee be adopted.

Upon motion of Dr. Christensen, seconded by Dr. Marsh, the unfavorable recommendation of the Resolutions Committee was sustained.

The resolution with reference to placement of *M.D.* on license plates, submitted by Dr. Amos R. Koontz, carried with it an unfavorable report from the Resolutions Committee. The resolution states:

"WHEREAS, we are reliably informed that new automobile license tags will be issued next year which will have letters in addition to numbers on them, and

"WHEREAS, certain states which follow this practice have issued license tags to physicians with the letters "M.D." on them, and

"WHEREAS, such a courtesy extended to physicians in Maryland, would be of great convenience to them, eliminating the necessity of having green (blue?) crosses attached to their cars, and facilitate their parking in spaces around hospitals.

"THEREFORE BE IT RESOLVED, that the Medical and Chirurgical Faculty of the State of Maryland respectfully requests the Governor of Maryland and the Commissioner of Motor Vehicles to have the identifying letters "M.D." placed on the license tags of Maryland physicians when the new tags are issued, and

"BE IT FURTHER RESOLVED, that the President of the Society be directed to appoint a Committee to wait on the Governor of Maryland in order that our case may be properly presented to him."

The House of Delegates failed to sustain the recommendation of disapproval by the Resolutions Committee and therefore, by virtue of this action the resolution became effective.

Under the heading of new business, Dr. Ross Pierpont inquired as to whether insurance companies were paying professional fees to hospitals. Dr. Richard F. Kieffer, who was present, clarified the ruling for payment of professional fees by the Maryland Hospital Service, Inc.-Maryland Medical Service, Inc. He stated that there is a specific provision for the payment of professional fees for graduate education and research, and that such fees would not be paid into general hospital funds. Dr. Osborne Christensen of Wicomico County stated that he believed such a system will grow and that it should be very carefully supervised. Dr. Pincoffs stated that insurance plans should be supported by the profession particularly where they are directed toward the care of the indigent and medically indigent. He stated that as insurance plans grow there will be certain disadvantages that will gradually develop. He also stated that the standards of professional training are being increased rapidly. In 1927 there were 200 residents in internal medicine, in 1937 there were 400 residents and in 1951 there were 3800 residencies in internal medicine.

Dr. Wise moved that the subject of hospitals collecting insurance fees be resubmitted to the Committee to Study an Insurance Problem, of which Dr. William L. Garlick is the Chairman. Seconded by Dr. Thomas Christensen and carried. It was specified that the Committee report to the House of Delegates at the Annual Meeting in April.

Dr. Pierpont moved that a Committee be appointed to explore the possibilities with reference to more satisfactory legislative and professional control of hospitals throughout the State. The Committee is to consider especially the licensing of new hospitals and more adequate control of professional relations. It is to report to the House of Delegates. This motion was seconded by Dr. Osborne Christensen and unanimously approved. Dr. C. R. Edwards recommended that the Committee analyze the Medical Practice Act, the system of issuing State licenses, and also that legal counsel of the Faculty be consulted before the Committee reports back to the House of Delegates.

Dr. Chatard made some brief comments with reference to the Journal and the publication of the Transactions in the August issue.

Dr. Compton issued an invitation to all the members of the Society to participate in the Pelvic Cancer meetings that are held on the third Thursday each month at the Faculty Building.

Dr. Compton also requested on behalf of Mrs. Compton, Chairman of the Creative Arts Show of the Woman's Auxiliary to the Medical and Chirurgical Faculty, that members throughout the State send in exhibits for the Creative Arts Show at the next Annual Meeting.

The meeting adjourned at 12:30 p.m.

George H. Yeager, M.D., *Secretary*

REPORTS PRESENTED AT SEMIANNUAL MEETING

Maryland Hospital Service, Inc. and Maryland Medical Service

Mr. President and Members of the House of Delegates:

In view of the authority vested in the Council by the House of Delegates at the April, 1952, meeting, every component medical society as well as the specialty groups were polled in reference to the contemplated change of income level of subscribers (family membership—$3,600 to $4,000). The result of this poll indicated that a majority favored the increased income level and the Maryland Hospital Service, Inc. and Maryland Medical Service, Inc., were so notified. Copies of criticisms and suggestions that were received by the Faculty office were sent to Mr. R. H. Dabney, Director of Maryland Hospital Service, Inc.-Maryland Medical Service, Inc.

Respectfully submitted,
Charles R. Edwards, M.D.
Chairman of the Council

September 12, 1952

Report of the Advisory Committee to the State Health Department

Mr. President and Members of the House of Delegates:

The Advisory Committee to the State Health Department met on August 11, 1952, at 1211 Cathedral Street, Baltimore. The members present were Doctors A. A. Pearre, Charles H. Williams, I. M. Zimmerman, and Walter D. Wise; Doctors Chesney, Pincoffs, Knotts, McCeney and Yeager being unable to attend.

The meeting was called to consider the matter referred to it by the House of Delegates on April 28, 1952, and any other complaints that might have arisen during the current year.

On April 28, 1952, the Tuberculosis Committee, under the Chairmanship of Dr. Lawrence M. Serra, reported to the House of Delegates making certain recommendations. The report is attached. The House of Delegates at first approved the recommendations of the Committee, but subsequently, during the latter part of the meeting on April 28th, Dr. J. W. Bird requested that the action taken concerning the recommendations of the Tuberculosis Committee be reconsidered, and he moved that the House of Delegates rescind a former action and refer these recommendations to the Advisory Committee of the Medical and Chirurgical Faculty, which has been formed to act in cooperation with the State Board of Health. After considerable discussion, the motion was carried.

Subsequent to this time and before the meeting of the Advisory Committee, Dr. Robert H. Riley appointed a special committee consisting of Doctors Esmond R. Long, John Barnwell, Maurice C. Pincoffs, Perry F. Prather, Otto. C. Brantigan, M. W. Jacobson, H. Vernon Langeluttig, Alfred Blalock and Charles R. Austrian, to review the tuberculosis situation in Maryland outside of Baltimore City and to make recommendations. This Committee met on July 11, 1952, and made recommendations which do not seem to disagree with those of the Medical and Chirurgical Faculty Committee on Tuberculosis. See copy of this Special Committee Report attached.

With the regular Committee of the Faculty and the Special Committee appointed by Dr. Riley, finding no material grounds for disagreement, the Advisory Committee suggests that the House of Delegates again adopt the report as submitted on April 28, 1952.

As the only matter before the Advisory Committee was in the field of tuberculosis, the Committee invited to be present Doctors Riley, Hetherington and Prather. After action on the above mentioned reports, complaints by the radiographers from two different localities were discussed. The complaint in both instances being that many patients other than indigent or medically indigent are receiving free chest pictures. It is agreed by all present that this is a difficult problem to work out with economic fairness to the radiographer and the individuals to be x-rayed, while at the same time recognizing that it is a mandatory public health need to protect the patient, the contacts of the patient and the general public.

After much discussion, it was agreed that the problem is not insurmountable but it involves many angles difficult to correlate differing in different localities. As indicated, the problem involves the patient and contacts, the practitioner, the Health Department, the Maryland Tuberculosis Association, the radiographer and, in many instances, a chest specialist. To work out this complicated problem with safety and no economic hardship is not a simple matter. The answer seems to resolve itself into finding the solution at the local level as has been done in some areas. (See the report from the Baltimore County Medical Association, page 416.) This may serve as an aid to other localities.

In considering this subject one cannot help but point out that much of the abuse of radiography done by the Maryland Tuberculosis Association with or without collaboration of the Health Department, is due to a family physician or other medical advisor, who finds it the easiest and simplest procedure.

Dr. Hetherington then presented for advice a plan for giving streptomycin and P.A.S. at home while the patient is waiting for hospitalization. This was submitted as a stop-gap procedure with recognition of its dangers and inadequacies. The Committee recommended it as the best available suggestion at this time. See recommendations attached.

Respectfully submitted,
Walter D. Wise, M.D., *Chairman*
Alan M. Chesney, M.D.
Maurice C. Pincoffs, M.D.
A. Austin Pearre, M.D.
George H. Yeager, M.D.
E. Paul Knotts, M.D.
Robert S. McCeney, M.D.
Charles H. Williams, M.D.
I. M. Zimmerman, M.D. (deceased)

TUBERCULOSIS COMMITTEE

Mr. President and Members of the House of Delegates:

The Tuberculosis Committee has met on two occasions. At the first meeting, Dr. Charlotte Silverman and Dr. Leon H. Hetherington were kind enough to give us valuable information as regards the progress of care being rendered to patients with tuberculosis in our State.

We are sorry to report that, according to figures submitted by Dr. Hetherington, the waiting list for entrance to the various sanatoria is long. For white males the list is approximately five and one half to six months behind schedule. For white females the period is six to seven weeks behind schedule. For colored females six months behind schedule, but within two months this figure should reach only two months behind schedule when new space will be available at Henryton. For colored males the period is six to seven months behind schedule. It has been pointed out that there is a rather substantial building program going on, and naturally, if the hospital can be appropriately staffed, Dr. Hetherington expects the waiting list to be sharply diminished.

The City of Baltimore, mainly through the efforts of Dr. Silverman along with the Staff of the Baltimore City Hospitals, has initiated an excellent program whereby cases requiring surgery may be admitted to the surgical division and returned home for further care. This allows a fair number of people in Baltimore City to obtain rather quick and necessary treatment.

At present, the State requires admission of patients directly to the sanatorium, before they are sent to one of the General Hospitals in Baltimore for surgery. It is the feeling of this Committee, that it would be well if the State could find it possible to arrange for appropriate consultation in cases which require surgery and to admit them directly to the General Hospitals for this purpose, so that the patient may return home for continued care until a bed is available in the sanatorium. This would obviate the necessity of making patients, who are amenable to surgical treatment, wait weeks and months before anything can be done and during which time, the condition may become worse so that they will no longer be candidates for such therapy. It is true, that whenever possible, the State does admit these patients to their hospitals (sanatoria) before their turn. While this may be commendable, it is felt that patients who need medical treatment are prevented from entering in chronological order.

At this point, we emphasize the continued efforts to admit patients to the sanatoria in accordance with the medical indication. In those instances where patients are required to wait at home for admission, it would be advisable to start medical treatment as soon as possible, and to this end, the City of Baltimore, through Dr. Silverman, has been supplying drugs such as Streptomycin and Paraaminosalicylic Acid. A similar arrangement for the patient in the State would be a definite improvement in the handling of their disease.

Because of the restrictions as regards the admission of tuberculous individuals by some of the General Hospitals, patients who are able to employ the services of private physicians cannot be admitted promptly. These patients usually require short term periods of hospitalization, varying from one to three weeks, after which they can be adequately treated at home. A more liberal attitude in the admission af known cases of tuberculasis by the General Hospitals would da much to expedite the care of these patients.

The Committee endorses the B.C.G. Vaccination Program which is being carried out in the City of Baltimore, and recommends that this type of work be extended throughout the State.

Doctors Silverman and Hetherington, wha guide the City and State Tuberculosis Programs, have expressed the desire to be cooperative and have furnished this Committee with whatever data has been needed. The Medical Profession and the people of Maryland can count on them to change the appalling situation which has existed for so many years.

I thank the members of this Committee for their cooperation in preparing the above report.

Respectfully submitted,
Lawrence M. Serra, M.D., *Chairman*
Otto C. Brantigan, M.D.
William A. Bridges, M.D.
Isadore Lyon, M.D.
John E. Miller, M.D.
Robert H. Riley, M.D.
Samuel Wolman, M.D.

REPORT OF SPECIAL TUBERCULOSIS COMMITTEE

(Appointed by Dr. R. H. Riley)

A Tuberculosis Advisory Committee, appointed by Dr. Riley and consisting of the following, met with Dr. Riley, Dr. Prather and the Chief of the Bureau of Tuberculosis on July 11, 1952: Dr. Esmund Long of the Henry Phipps Institute, Philadelphia; Dr. John Barnwell, Chief, Division of Tuberculosis Services of the Veterans Administration; Dr. Maurice C. Pincoffs; Dr. Otto C. Brantigan; Dr. M. W. Jacobson; Dr. H. Vernon Langeluttig and Dr. Alfred Blalock were present. Dr. Charles R. Austrian, who was originally appointed on the Committee, was unable to attend since he was on vacation.

The points discussed at the meeting were as follows:

Mass X-Ray Surveys*—It was the recommendation of Dr. Long that these should be continued and there was no dissent from other members of the Committee. Dr. Long emphasized the importance of x-raying all General Hospital admissions to detect many cases of unknown tuberculosis.*

BCG Vaccination*—Dr. Long recommended that a BCG program should only be as large as could be afforded financially and with the number of personnel required it should not exceed that which could be carried along with a balanced health program. He advised that BCG vaccination of non-reactors in hospitals is advisable and that BCG vaccination in the community could be used advisedly in some groups in which tuberculosis was predominant. He does not advise mass inoculation of the public and does recognize that there is still variation of opinions as to the value of BCG. He does, however, advise that in hospital groups it should be utilized.*

Antibiotic Home Treatment*—The group then brought up for discussion the use of antibiotics prior to admission to a Tuberculosis Hospital. Dr. Long cited that the Henry Phipps Institute has been carrying on a rather active program in its own population segment in Philadelphia due to the shortage of tuberculosis beds in that city. (Philadelphia has a waiting list of about 500.) He advised that the results are far from satisfactory and is of the opinion that many failures are due to the fact that he does not believe the majority of the patients will take their PAS as prescribed, due to gastric irritability and also that they do not undergo the amount of rest at home that would be gained in a Tuberculosis Hospital.*

Dr. Barnwell is also of the opinion that antibiotic therapy treatment prior to hospitalization contained a great number of pitfalls and that the usual satisfactory response gained in hospitals could not be duplicated in home treatment.

Comments from Dr. Jacobson seemed to indicate his favorable reaction to use of antibiotics in the home.

The Chief of the Bureau of Tuberculosis advised the members of the Committee that provision was being made to attempt the establishment of antibiotic therapy in selected cases prior to hospital admission, and to accompany this, an intensive individual patient educational program on the part of the nurses or others working with these patients to keep them repeatedly advised as to the importance of an overall treatment plan, that each patient is treated as an individual case, that therapy quite often needs to be combined with medical and at times surgical treatment in order to gain a satisfactory end result.

It is recognized that there will be some patients who will refuse hospitalization after treatment has been instituted at home. Dr. Pincoffs advised as to the importance of bringing the medical profession into a cooperative plan which was recognized by all present.

The Chief of the Bureau of Tuberculosis also informed the group that discussion was underway with the Superintendents of the State Tuberculosis Hospitals to determine if some patients under antibiotic therapy might be discharged at a slightly earlier date with antibiotic treatment continued at home in order to reduce the waiting list. These patients who are discharged at a somewhat earlier date would have to be screened very carefully, home conditions investigated and the cooperativeness of the patient determined prior to such discharge. The group was informed as to the length of the waiting list at the present time which is markedly reduced as compared to the number on the waiting list as given to the Tuberculosis Committee of the Medical and Chirurgical Faculty just prior to their filing their recommendations with the Faculty. The oldest application on the waiting list of adults at the present time is white, male, early in April; there were only two white female applicants on the waiting list at the time of this Committee meeting; waiting list for colored females is approximately one and a half months and the waiting list for colored males is less than three months.

The next question raised was the question of admitting patients for chest surgery directly from the home into a general hospital and then returning the operated patient to his home and there to await a bed in a Tuberculosis Hospital. Dr. Brantigan informed us that such a program has been carried on at Baltimore City Hospitals; included in this group are individuals for pneumothorax, pneumoperitoneum, pneumolysis and major chest surgery. We did not have the actual number of patients who have had major surgery in this program.

The group was informed that pre-operatively the State Tuberculosis Hospital cases are prepared by at least three months and frequently more of streptomycin and PAS prior to surgery and that our best results are obtained after the cellular elements of the tuberculous lesion have been eliminated by antibiotic therapy. In addition to this, a complete surgical workup is made including bronchoscopy, electric cardiograms, kidney studies, etc.

It was the impression that the majority of the Committee were of the opinion that the best results are to be obtained from patients under long term antibiotic therapy, transferred from Tuberculosis Hospitals to surgery and then returned to the Tuberculosis Hospitals for convalescent treatment. Dr. Brantigan seemed to be of the opinion that since the State waiting list, at the present time, averages less than three months duration that it is possible that a program of admitting patients directly from the outside into general hospitals and then back to the home is not as imperative at the present time as he considered it several months ago when the waiting list was much longer.

Dr. Long and Dr. Barnwell emphasized the fact that outpatients treated with streptomycin and PAS would be far from satisfactory and that as soon as sufficient beds were available in the State that all patients in need of such treatment would be better off in a hospital. They also emphasized that even under present conditions that patients in preparation for this surgery should be in a Tuberculosis Hospital receiving antibiotics for a sufficiently long period of time before they underwent surgery.

BALTIMORE COUNTY HEALTH DEPARTMENT

County Office Building, Towson 4, Maryland

July 18, 1952

Dear Doctor:

An important change in the procedure of the Baltimore County Health Department chest clinics will be effective August 1, 1952. This plan has evolved from careful consideration of various difficulties which have existed, and represents the cooperative effort of the Executive Committee of the Baltimore County Medical Association, the Bureau of Tuberculosis of the Maryland State Department of Health, the Baltimore County Public Health Association and the Baltimore County Health Department.

The new procedure is outlined as follows:

1. *Patients reporting to clinics will be X-rayed, but no other initial studies will be done unless specifically requested by the referring physician.*
2. *A report of the X-ray findings, interpretation, and recommendations will be sent to the referring physician from the clinic.*
3. *Accompanying the report will be a card which is to be returned to the clinic as promptly as possible. The physician will check this card to indicate: (a) if he will assume* **all** *follow-up of the patient; (b) if he wishes* **any** *Health Department services; or (c) if he wishes the Health Department to assume* **all** *follow-up of the patient. (Sample of wording on card at end of this letter.)*
4. *In those cases in which the physician wishes to refer a patient to a particular chest clinic for assuming all follow-up of the patient it is extremely important that the physician give to the patient referred a written request for such services so that the patient may present this request at the clinic.*
5. *It has been agreed upon both by the Executive Committee of the Baltimore County Medical Association and the Baltimore County Health Department that investigations in the homes will continue to be made to find contacts of known cases and these contacts will be followed to determine any evidence of tuberculous infection. Any positive cases found among contacts will be referred to their private physician.*

In the case of patients on medical care, they will, as is required by law, be given complete clinic services, but a full report of all findings will be sent to the physician to whom they would go in the event of acute illness, so that he may be informed as to their tuberculous status.

It should also be emphasized that when a patient does not have a physician at the time of his X-ray, he will be supplied with a list of all physicians in the clinic area and asked to designate one.

MARYLAND STATE DEPARTMENT OF HEALTH
BUREAU OF TUBERCULOSIS

August 6, 1952

TO: DEPUTY STATE HEALTH OFFICERS AND TUBERCULOSIS CLINICIANS

FROM: Dr. Leon H. Hetherington, Chief, Bureau of Tuberculosis

RE: Treatment of Tuberculosis prior to hospital admission

The State Department of Health is prepared to supply Streptomycin and PAS tablets for the treatment of tuberculosis prior to hospital admission on those carefully selected cases which are indigent, medically indigent and others reporting to the County Tuberculosis Clinics. We wish, however, to emphasize that this treatment in the home is not the treatment of choice; that the response in hospitals is almost always uniformly better and the patient has a better opportunity for permanent results. Antibiotic therapy is only a portion of a planned treatment in each individual case of tuberculosis.

The Streptomycin Committee has set the dosage at: 1 gram of Streptomycin to be given twice weekly and 10 grams (20 tablets) of PAS to be given in four equally divided doses a day (5 tablets *per dose). In the case of meningitis or miliary tuberculosis the treatment is 1 gram daily plus the 10 grams of PAS and these cases (meningitis or miliary) will be admitted out of schedule. It is absolutely essential for the health officer, the nurse and the tuberculosis clinician, in conjunction with any private physicians involved, to insist that these patients take their PAS tablets; otherwise, the treatment most likely may fail and the individual become resistant to Streptomycin at an earlier date thereby defeating the ultimate long range treatment plans which are directed toward recovery.*

There must be a continual education and re-education program with each individual patient. It is also to be understood that each patient must have an application filed for hospitalization as a precaution and that he or she agrees to take a tuberculosis hospital bed when it can be assigned.

All X-rays, the clinical record and a temperature record (if one has been kept) are to be sent directly to the Chief of the Bureau of Tuberculosis for review by the Streptomycin Board. At all times the clinical record **must** *contain the temperature record of patient.*

The Streptomycin Board will meet once a week or more frequently if necessary to review these cases and send the results of its opinion to you. From time to time, there may be some patients on "long term" Streptomycin treatment in our hospitals, who, if home conditions are satisfactory and if their response is satisfactory, might be sent back to your county for continuation of treatment until the full time limit has expired.

For your own information, we are using "long term" treatment in our hospitals ranging probably from eight to twelve months depending upon the individual case. In these cases it is also important that a close supervision of medication is maintained.

When all of the new beds for tuberculosis are opened in the State Hospitals, the City Hospitals and the Veterans Hospital, our waiting list, if it maintains its present number, will be completely exhausted and when that time comes it is not our present intention to supply Streptomycin and PAS for outpatient treatment. This treatment is, therefore, to be considered as an interim treatment.

If there is anything about this new procedure which is not clear, please do not hesitate to call me. I hope this plan will be entirely satisfactory to you and your patients, and your cooperation in helping to make it effective will be most appreciated.

Very truly yours,
William H. Warthen, M.D.
Deputy State and County Health Officer

Sample of wording on card sent with this letter:

BALTIMORE COUNTY HEALTH DEPARTMENT

Dear Doctor:

As you may see from the attached X-ray report, your patient needs further examination to establish a correct diagnosis. Would you please indicate on the reverse side of this card your wishes in this case and return the card promptly to the Health Department.

TUBERCULOSIS REFERRAL

Name of Patient..............Age..Sex..Color..........
Address..
I will take care of this patient privately..................
I will follow this patient privately but desire the following services from the Health Department....................
....
....
I request the Health Department to follow this patient....
....
....
Signature of Physician

PLEASE RETURN THIS CARD IMMEDIATELY IN THE ENCLOSED ENVELOPE.

Report of Resolutions Committee

Mr. President and Members of the House of Delegates:

At its meeting in April 1952 the House of Delegates authorized the formation of a Resolutions Committee, and this is the inaugural report of said Committee, which Dr. Alan M. Chesney, the President, appointed. This report has been distributed to the members of the House of Delegates.

The Baltimore County Medical Association has submitted three resolutions—1.(a); 1.(b) and 1.(c).

1.(a) *BE IT RESOLVED that the Baltimore County Medical Association recommends that the members of the Council of the Medical and Chirurgical Faculty of the State of Maryland be limited to two (2) consecutive terms.*

This resolution necessitates an amendment to the Constitution and By-Laws for its adoption. The Committee recommends that this resolution be referred to the Committee on Constitution and By-Laws. The Committee is favorable, however, to its adoption.

1.(b) *BE IT RESOLVED that the President of the Medical and Chirurgical Faculty should be alternated each year between the Baltimore City Medical Society and the county organizations.*

If this body feels it is necessary that there be an amendment to the Constitution and By-Laws then this Committee recommends that it be referred to the Committee on Constitution and By-Laws for further study. If it is to be a policy of the Medical and Chirurgical Faculty, authorized by the House of Delegates, this Resolutions Committee makes a favorable report.

1.(c) *BE IT RESOLVED that the Nominating Committee for the officers of the Medical and Chirurgical Faculty of the State of Maryland be elected from the floor of the House of Delegates.*

If the House of Delegates desires further study, the Resolutions Committee recommends that this resolution be referred to the Committee on Constitution and By-Laws as it would mean that the By-Laws would have to be amended. Under the Constitution and By-Laws the President appoints the Nominating Committee not later than three months prior to the Annual Meeting. The Committee reports unfavorably on this resolution.

The following resolution was submitted by Dr. Mark V. Ziegler for Dr. Page C. Jett:

Whereas, The Medical Care Program was INITIATED (historically based) upon a request of the Medical and Chirurgical Faculty and was unanimously approved by the Faculty before being enacted into law, and

Whereas, the principles of the program and its operation are basically satisfactory to the medical profession, and

Whereas, the program has often been compelled BECAUSE OF INADEQUATE APPROPRIATION to reduce the scope of services, the number of beneficiaries, or to pay only part of its just obligations from time to time, therefore be it

Resolved, that the Medical and Chirurgical Faculty of Maryland endorses the principles and operations of the aforementioned program and recommends that sufficient funds be appropriated to EFFICIENTLY carry out the program as now constituted; and be it further

Resolved, that the Secretary of the Medical and Chirurgical Faculty be instructed to send a copy of these resolutions to the Governor of Maryland; to the respective members of the Senate Finance Committee, and the House Ways and Means Committee of the General Assembly; to the Director of the Maryland State Health Department, and to the Commissioner of Health of Baltimore City.

The Resolutions Committee reports favorably on this resolution.

The following resolution has been sent in by Dr. Amos R. Koontz:

There has always been the complaint that our Medical Society is run by a few people. That is probably because in any Society there are only a few people who are willing to do the work. There are always drones and always workers in every group. The drones cannot be gotten to work no matter how much responsibility is thrust upon them. However, to stimulate more interest and to secure more active participation by all members of our Society in the affairs of the Society.

BE IT RESOLVED, that it is the desire of the House of Delegates that each new President, in appointing his committees, appoint not more than half of those who served on each committee the year before, and that in no instance shall a man serve on any committee longer than three consecutive years.

The Committee reports unfavorably on this resolution. However, the House may wish to have this recommendation given further study, and if so said resolution should be referred to the Committee on Constitution and By-Laws. In some instances under the Constitution and By-Laws the Committees, unless otherwise indicated, are appointed by the President. A few Committees are elected by the House of Delegates.

The following resolution has been referred by Dr. Amos R. Koontz:

WHEREAS, we are reliably informed that new automobile license tags will be issued next year which will have letters in addition to numbers on them, and

WHEREAS, certain states which follow this practice have issued license tags to physicians with the letters "M.D." on them, and

WHEREAS, such a courtesy extended to physicians in Maryland, would be of great convenience to them, eliminating the necessity of having green (blue?) crosses attached to their cars, and facilitate their parking in spaces around hospitals.

THEREFORE BE IT RESOLVED, that the Medical and Chirurgical Faculty of the State of Maryland respectfully requests the Governor of Maryland and the Commissioner of Motor Vehicles to have the identifying letters "M.D." placed on the license tags of Maryland physicians when the new tags are issued, and

BE IT FURTHER RESOLVED, that the President of the Society be directed to appoint a Committee to wait on the Governor of Maryland in order that our case may be properly presented to him.

The State Roads Commission Chairman, Mr. Mudd, assumed an unfavorable attitude towards this suggestion when he communicated with Dr. Yeager and the Committee feels that it would be very unwise to go to the Governor direct. Unfavorable report.

The Resolutions Committee wishes to remind the House of Delegates that amendments to the Constitution may be acted on by the House of Delegates at an Annual Session, providing that the amendment has been presented at a previous Annual Meeting; and the By-Laws may be amended by a majority vote of the House of Delegates present at that session after the amendment has laid on the table for one day; or at a Semiannual Meeting, providing the amendment has been sent to all the Delegates at least 30 days prior to the Semiannual Meeting.

Respectfully submitted,
J. W. Bird, M.D., *Chairman*
Charles R. Austrian, M.D.
Robert V. Campbell, M.D.
T. Nelson Carey, M.D.
William D. Noble, M.D.

Discussion of the Medical Care Program

Mark V. Ziegler, M.D.[1]

The Chairman, Dr. Alan M. Chesney, called upon Dr. Mark V. Ziegler, Secretary of the Council on Medical Care to comment on the following items which were raised as questions by the Delegates in respect to the Resolution under discussion:

(a) Define medically indigent
(b) State the maximum allowable annual income which would make a family of four persons eligible for certification as medically indigent.
(c) Comment on the current financial status of the County Medical Care Program.

The Act authorizing the Medical Care Program provides that the State Board of Health shall administer a program of medical care for indigent and medically indigent persons. The State Board of Health defines "an indigent individual as one who is receiving financial assistance from the Department of Public Welfare." "A medically indigent person is one who is not a recipient of public assistance, but who is unable through his own resources, or resources available to him, to provide himself and his dependents with proper medical, dental, nursing and hospital care without depriving himself or his dependents of food, shelter, clothing and similar necessities."

The maximum allowable annual income for certification as medically indigent, for a family of four persons varies in the various countries from $1,272 to $1,452. This differential of $180 in the annual income is occasioned by the cost of living index, especially in respect to rents and cost of fuel. Baltimore and Montgomery Counties are in the higher income bracket while Caroline, Kent, Queen Anne's, St. Mary's, Somerset and Talbot are in the lower income bracket.

The income scales used in determining a person's eligibility for medical care as a medically indigent are almost identical to the income scales used by the Department of Public Welfare in certifying persons for public assistance. The income scales for the medically indigent are, in fact, lower than those used by the Department of Public Welfare in certifying persons for general hospital care.

---

[1] Secretary, Council on Medical Care, State Department of Health.

The subsistence level for the medically indigent is so low that it does not allow any margin to meet the cost of either ordinary or unusual illness. The County Medical Care Program permits such persons to apply for medical care when needed without being stigmatized as paupers.

With reference to the current financial status of the County Medical Care Program, I have to report that the Legislature appropriated $637,085 to meet the cost of operating the County Medical Care Program during the fiscal year July 1, 1952 through June 30, 1953. This appropriation is less than any fiscal year's appropriation for the past three years. The Governor's budget allowance to operate the County Medical Care Program for the current fiscal year was in the amount of $687,085. The General Assembly in appropriating $637,085 reduced the Governor's allowance by the sum of $50,000.

The cost of operating the County Medical Care Program during the fiscal year ending on June 30, 1952 amounted to $708,014. It will be noted that the current appropriation is $70,929 less than the past year's expenses. The annual appropriation is apportioned into twelve monthly allotments according to seasonal demands for medical care. The obligations incurred for medical care during the month of July, 1952 exceed the July allocations by the sum of $3,794. The obligations incurred for medical care during the month of August, 1952 exceeds the August allotment by the sum of $5,248.

Dr. R. H. Riley, Director, State Department of Health, authorized me to process the physicians bills for payment in full for the months of July and August, 1952, notwithstanding the fact that they exceeded the allotment by the sum of $9,042. Dr. Riley was rather hopeful that when the matter is brought to the Governor's attention, that the Governor would approve of a budget amendment to at least meet the deficit already incurred. The demands for medical care services is lighter in July and August than in other months of the year. It is estimated that our total obligations for the current fiscal year will exceed the fiscal year's appropriation by approximately $70,000.

The solution to our present financial dilemma seems to lie in either the securing of additional resources in the amount of $70,000 in order to continue services in accordance with the previously approved policies, or in the prorating of physicians' dentist's and hospital outpatient bills for the remainder of the fiscal year (10 months) at the rate of 80¢ on the dollar.

For complete Semiannual Meeting program see pages 446–448

* * * *

ANNUAL MEETING

HOUSE OF DELEGATES

Deutsches Haus, Second Floor Auditorium, 1212 Cathedral Street, Baltimore

SPECIAL SESSION[1]

Monday, April 27, 1953, 2:00 p.m.

The 203rd meeting of the House of Delegates was called to order at 2:00 p.m., by Dr. Maurice C. Pincoffs, President, presiding. Dr. Chesney, as the immediate Past President, presented the gavel to Dr. Pincoffs.

Dr. Pincoffs made several preliminary announcements relative to the method of conducting the business of the House of Delegates; in addition he explained that only delegates had the privilege of the floor. He also announced that the roll call of this assembly would be by registration. The following members registered: Doctors Conrad Acton, David H. Andrew, Charles R. Austrian, D. F. Bartley, O. H. Binkley, J. W. Bird, Helen Bowie, Otto C. Brantigan, Read N. Calvert, R. V. Campbell, Ferdinand E. Chatard, IV, J. Albert Chatard, Alan M. Chesney, Thomas A. Christensen, Bernard J. Cohen, Melvin B. Davis, Everett S. Diggs, Richard C. Dodson, C. Reid Edwards, Monte Edwards, Wolcott Etienne, John S. Fenby, Whitmer B. Firor, Palmer H. Futcher, William E. Gilmore, Bowie L. Grant, Wilson Grubb, Lewis P. Gundry, William Hanks, John M. Haws, Robert F. Healy, Hugh J. Jewett, Emmett L. Jones, James R. Karns, Harry F. Klinefelter, Jr., J. H. Mason Knox, III, Louis Krause, Franklin E. Leslie, William B. Long, Hunter R. Mann, Jr., W. Kenneth Mansfield, James T. Marsh, Waldo B. Moyers, W. O. McLane, Hugh B. McNally, Claude W. Mitchell, Zachariah R. Morgan, William D. Noble, Edmund R. Novak, Thomas R. O'Rourk, John W. Parsons, A. Austin Pearre, Ross J. Pierpont, Maurice C. Pincoffs, M. C. Porterfield, H. William Primakoff, Peter P. Rodman, Norman E. Sartorius, Jr., John E. Savage, Richard T. Shackelford, Frank E. Shipley, W. H. Townshend, Jr., W. Kennedy Waller, William H. Warthen, George J. Weems, William W. Welsh, T. B. Whaley, A. F. Whitsitt, Palmer F. C. Williams, Arthur O. Wooddy, Theodore E. Woodward, George H. Yeager.

The minutes of the meeting of September 12, 1952, were unanimously approved as distributed by mail.

---

[1] See pages 420 to 421 for reports adopted at this meeting.

Dr. Pincoffs explained that all Committee reports had been abstracted and circularized to every member of the House of Delegates. It was pointed out that many of these reports were routine and did not carry specific recommendations. Upon motion of Dr. Chatard and seconded by Dr. Jewett, all Committee reports not carrying specific recommendations were unanimously approved.

Dr. Etienne, of Prince George's County, presented a recommendation that Dr. W. Allen Griffith be made an emeritus member. It was ordered that this recommendation be referred to the Council for appropriate study. (See page 421.)

The following members upon recommendation of Council were unanimously approved for emeritus membership:

Dr. Anna S. Abercrombie, Baltimore City
Dr. Wilbur F. Skillman, Baltimore City
Dr. Lloyd B. Whitham, Baltimore City
Dr. Charlotte B. Gardner, Cumberland
Dr. Francis A. C. Murray, Cumberland
Dr. Thomas L. Higdon, Wayside, Charles County
Dr. U. G. Bourne, Sr., Frederick
Dr. Charles H. Conley, Sr., Frederick
Dr. William M. Smith, Frederick
Dr. Levin J. Sothoron, Charlotte Hall, St. Mary's County
Dr. Edward Kirby Lawson, Oxford, Talbot County

COMMITTEE RECOMMENDATIONS

Board of Medical Examiners. A request from the Board of Medical Examiners was reviewed and unanimously endorsed. The request stated

> *"The Board of Medical Examiners feels that the Naturopaths, some of whom are very probably practicing medicine, should be vigorously prosecuted wherever they are located. The Board would like to have the full backing and support of the Medical and Chirurgical Faculty in this matter."*

Editor, Maryland State Medical Journal. Dr. Pincoffs emphasized the need for office space for the Editorial staff of the Journal. On motion by Dr. Campbell, the House of Delegates placed itself on record as congratulating Dr. George Yeager and the staff, for a fine job.

Dr. Chatard brought to the attention of the Society the report of Dr. Yeager in which he has stated that this would be his last annual report as Secretary of the Medical and Chirurgical Faculty. It was moved that the Society extend to Dr. Yeager a vote of sincere thanks for the very excellent work which he has carried out in his official position in these past years. This was seconded and carried unanimously.

Medical Advisory Committee to Selective Service. Dr. Graham personally presented the status of physicians in Maryland under Public Law #779, "Doctor Draft Law." He also stated that hearings are being held with reference to a continuation of this law and explained that it represents practically a two-year extension of the present law. He requested cooperation of the State Medical Society in complying with the terms of the law.

Library Report. Dr. Louis Krause presented the Library report and stated the Library is in urgent need of more shelf space. He also stated that there is an urgent need for certain salary adjustments.

Committee for Better Distribution of Doctors Throughout the State. Dr. Allen F. Voshell presented the report of the Committee for Better Distribution of Doctors Throughout the State. The report contained the following:

> *"The proper development of this project might well be one of the most valuable and far reaching services of the Medical Faculty of Maryland to the State of Maryland. The Committee requests further direction as to how it should proceed."*

Dr. Graham stated that the Medical Advisory Committee to Selective Service is helping find locations for doctors in the State of Maryland and thereby aiding in their distribution. It was suggested that the recommendation of the Committee for Better Distribution of Doctors Throughout the State could be developed to a more satisfactory extent by cooperation with the Medical Advisory Committee to Selective Service.

Committee to Study Legislative and Professional Standards and Staff Relations of Hospitals. The recommendation of the Committee to Study Legislative and Professional Standards and Staff Relations of Hospitals was referred to the Resolutions Committee for appropriate action.

Committee to Study an Insurance Problem. The following recommendations contained in the report of the Committee to Study an Insurance Problem were approved by the House of Delegates upon motion of Dr. Chesney

> *"The Committee recommends that all such commercial insurance fees be collected in the same manner as the nonprofit insurance, i.e., (1) by the physician who accepts the responsibility of the patient or (2) by an authorized officer, a physician, to go into a fund for furtherance of graduate medical education."*

Legislative Committee. The recommendation of the Chairman of the Legislative Committee with reference to the employment of a Legislative agent for the long session of the State Legislature was brought to the attention of the House of Delegates as a matter of information.

Maternal and Child Welfare Committee. The report of the Maternal and Child Welfare Committee was approved by the House of Delegates. It was brought to the attention of the delegates that the Committee is anxious to review all deaths of women who are, or who recently have been pregnant even though the death is evidently not maternal. Since the only source of information is the death certificate, the physicians are urged to note on this document the fact that the patient was pregnant or had recently delivered.

New Building Committee. The report of the New Building Committee was presented by Dr. Pincoffs who ruled that no action could be taken on the recommendation of making an additional assessment per member, as this was a matter of policy and therefore would be referred to the Resolutions Committee.

Postgraduate Educational Committee. The report of the Postgraduate Educational Committee was summarized by Dr. Pincoffs and elaborated upon by Dr. Stafford, the Chairman of that Committee. No action was taken.

Committee on Rural Medicine. The report of the Committee on Rural Medicine was summarized by Dr. Pincoffs and the problem of enrollment in Blue Cross by members of rural communities was discussed. It was moved by Dr. Parsons and seconded by Dr. Christensen that the House of Delegates authorize the officers of the Faculty to initiate a study of present payment insurance practices and offer some solution of remedying the present defect.

Advisory Committee to the State Health Department. Dr. Chesney pointed out that this Committee unanimously recommends approval of the proposed survey by the Department of Health of fatal accidents other than industrial and traffic in the counties of Maryland. The recommendation specified that the investigating approach to the family in every instance should be through the family physician. The recommendation was unanimously approved.

Committee to Study Question of Placing "M.D." on Automobile License Plates. Dr. Pincoffs stated that inadvertently the report of Dr. Koontz's committee regarding the use of distinctive automobile license plates for physicians had been omitted from the Summary of Reports supplied to the delegates. Dr. Koontz met with the Governor and received a favorable reaction to the recommendation that doctors' automobile license plates carry the letters "M.D." Subsequently, however, the Commissioner of Motor Vehicles found it impossible to comply with the request.

Blue Cross and Blue Shield. Dr. Jewett personally reported to the House of Delegates on the present status of Blue Cross and Blue Shield in the State. No action was required.

Committee for the Study of Certain Phases of Medical Economics. At the request of Dr. Moyers, there was general discussion of the report of the Committee for the Study of Certain Phases of Medical Economics. Upon motion of Dr. Etienne, and duly seconded, the following recommendations were adopted:

1. *The Medical and Chirurgical Faculty of Maryland places itself on record as supporting Bills H.R. 10 and H.R. 11 and will so inform the Maryland Senators and Congressmen. Component Societies are to be notified of this action and to be requested to also inform the Maryland Senators and Congressmen.*
2. *The Medical and Chirurgical Faculty commends Mr. J. W. Holloway, Jr., Director of the American Medical Association Bureau of Legal Medicine and Legislation on his effort to change the tax ruling on postgraduate education.*

The meeting adjourned at 4:15 p.m.

Respectfully submitted,
George H. Yeager, M.D., *Secretary*
Everett S. Diggs, M.D., *Assistant Secretary*

FIRST SESSION

Tuesday, April 28, 1953, 2 p.m.

The 204th meeting of the House of Delegates was called to order on Tuesday, April 28, 1953 in the Deutsches Haus, 1212 Cathedral Street, Baltimore, with Dr. Maurice C. Pincoffs, President, presiding.

The roll call was by registration and the following members were present: Doctors Conrad Acton, David H. Andrew, Charles R. Austrian, D. F. Bartley, O. H. Binkley, Helen Bowie, Otto C. Brantigan, Read N. Calvert, R. V. Campbell, F. E. Chatard, J. A. Chatard, Alan M. Chesney, Thomas C. Christensen, Bernard J. Cohen, Melvin B. Davis, Leslie E. Daugherty, Everett S. Diggs, Richard C. Dodson, C. Reid Edwards, Monte Edwards, Wolcott Etienne, John S. Fenby, Whitmer B. Firor, Palmer H. Futcher, Bowie L. Grant, Donald B. Grove, Wilson Grubb, William Hanks, John M. Haws, Alan D. Houser, Robert F. Healy, James G. Howell, Hugh J. Jewett, Emmett L. Jones, James R. Karns, Harry F. Klinefelter, Jr., J. H. Mason Knox, III, William B. Long, Hunter R. Mann, Jr., W. Kenneth Mansfield, James T. Marsh, W. O. McLane, Hugh B. McNally, Claude W. Mitchell, Zachariah R. Morgan, Waldo B. Moyers, William D. Noble, Richard C. Norment, III, Edmund R. Novak, Thomas R. O'Rourk, John W. Parsons, A. Austin Pearre, Ross Z. Pierpont, Maurice C. Pincoffs, M. C. Porterfield, Norman E. Sartorius, Jr., John E. Savage, Richard T. Shackelford, W. H. Townshend, Jr., William W. Welsh, T. B. Whaley, A. F. Whitsitt, Arthur O. Wooddy, Theodore E. Woodward and George H. Yeager.

The reading of the minutes of the meeting held on Monday, April 27, 1953, were dispensed with upon duly approved motion.

Dr. W. Allen Griffith, College Park, Prince George's County, upon nomination of the Prince George's County Medical Society, and recommendation of Council, was approved for emeritus membership.

Dr. A. Austin Pearre, Chairman of the Committee on Constitution and By-Laws, presented contemplated amendments to the Constitution and By-Laws (see pages 457–460 for proposed amendments). Each proposed amendment after being read was discussed from the floor.

Constitutional amendments comprising Article V, Section 2; Article VI, Section 2 and Article VII, Section 3, were not modified by the House of Delegates, and are to be presented for final action at the Annual Meeting in April 1954. (See pages 457–458.)

The proposed modification to Article XI, Section 2, relative to Funds and Expenses evoked considerable discussion. It was considered unacceptable and the House of Delegates recommended that it be referred back to the Committee on Constitution and By-Laws for further study and re-wording. (See page 458.)

After presentation of the proposed changes in the Constitution, Dr. Pearre presented the following proposed changes in the By-Laws (see page 458):

Chapter II—Dues and Assessments
Section 1. Active Members.
Change: $20.00 to read $30.00
Change: $35.00 to read $45.00
Section 1. a. Change: $20.00 to read $30.00
Section 1. b. Change: $35.00 to read $45.00
Section 1. d. To be deleted
Section 1. Last paragraph. The words "assessment is" to read "DUES ARE"

House of Delegates' action referred this back to the Committee on Constitution and By-Laws for further study. In referring it back to the Committee, two alternative proposals, as follows were recommended for study, e.g.,

Presented by Dr. Mansfield, Baltimore City:
Chapter II—Dues and Assessments
Section 1. Active Members. Funds shall be raised by per capita dues to be paid by every member of the Component Societies. The amount of the dues shall be $30.00 per capita per annum for active members in the County Societies and $40.00 for active members of the Baltimore City Medical Society, with the following exceptions: b. In the Baltimore City Medical Society the following rate shall prevail: for the first year in private practice the dues shall be $15.00 per capita per annum; for the second year, $25.00; and the third year and thereafter $40.00.

Presented by Dr. Mitchell, Montgomery County:
Chapter II—Dues and Assessments
Section 1. Active Members. Inasmuch as there has always been a proportional assessment between the County Societies and the City of Baltimore, that an attempt be made to maintain this by making a 50% proportional increase in assessment by which "$20.00" would be changed to read "$30.00" and "$35.00" would be changed to read "$52.50."

It was further requested that the $3.00 annual dues for each member of the Baltimore City Dental Society be explained. (See page 458.)

Chapter VIII, Section 8. Professional Conduct Committee. Dr. Etienne presented the following addition to the proposed change in this By-Law (see pages 425, 459):

> The provisions of this section shall not be in effect against Component Society members providing such Society shall have in effect a regularly constituted Professional Conduct or Grievance Committee unless referred to the Faculty Committee by the constituent society. (See page 425.)

In the proposed amendment: Chapter VII, Section 6 (c) and in the proposed amendment, Chapter IX, Section 9 (see pages 425, 459, and 460), Dr. Welsh recommended that the words "each subsequent year to and including" be struck out. It was also moved that the proposed amendment to Chapter I, Section 4, shall not be as proposed but that it shall stand as it is written with the addition "as applied to alleged malpractice occurring after he became an emeritus member but not as applied to alleged malpractice occurring during the time of his practice during which he was in all other respects eligible."

Dr. Noble, Chairman of the Resolutions Committee, presented the following resolutions (see pages 423–424 for resolutions):

1. Resolution from the Montgomery County Medical Society that the House of Delegates request the Governor to give consideration to the appointment of a practicing physician from the counties of Maryland in filling the vacancy on the State Board of Health. This was presented to the House of Delegates with the approval of the Resolutions Committee. The House of Delegates concurred.

2. A request, that a pathologist be included in the nominations for membership in the Board of Medical Examiners of Maryland, was presented to the House of Delegates with the recommendation that the resolution should be referred to the Council of the Medical and Chirurgical Faculty for action. Dr. Klinefelter moved acceptance of this recommendation. Dr. Porterfield seconded the motion. It was the consensus of the House of Delegates that it would be unwise to have every specialty represented on the Board. The original request was lost by majority vote.

3. A resolution from the Anne Arundel County Medical Society in reference to the "Doctor Draft" Law (Public Law #779) was disapproved by the Committee, and the House of Delegates concurred. The Committee then submitted a resolution presented by Dr. R. Walter Graham, Jr., with committee endorsement. The House of Delegates approved Dr. Graham's resolution.

4. A resolution with reference to the establishment of a fund for needy doctors, was presented to the House of Delegates with Committee approval. The House of Delegates concurred.

A request from the Heart Association of Maryland, for endorsement for a contemplated study for the establishment of a work classification unit for cardiac patients, was approved in principle.

Dr. Chatard presented a resolution thanking the Woman's Auxiliary of the Baltimore City Medical Society for the excellent work done during the past year and for the splendid social affair that inaugurated the opening of the Annual Meeting. Dr. Binkley, who endorsed the resolution, expressed the hope that the dance would become an annual affair. The House of Delegates unanimously adopted the resolution, which follows:

"Be it Resolved, that the House of Delegates of the Medical and Chirurgical Faculty of Maryland wishes to extend to The Woman's Auxiliary to the Baltimore City Medical Society our sincere appreciation and thanks for the wonderful work they have done for our Faculty in the last year, and wishes to call attention to their efforts in planning and carrying to its great success, the first large dance and floor show on Monday, April 27th—a most enjoyable occasion."

The meeting was then recessed for five minutes.

SECOND SESSION

Tuesday, April 28, 1953

The 205th meeting of the House of Delegates, held on Tuesday, April 28, 1953, was reconvened after a five minute recess. Dr. Pincoffs, the President, called the Second Session to order.

Dr. Melvin B. Davis, Chairman of the Nominating Committee, presented the nominations of the Nominating Committee for the Officers etc., for 1954, as follows:

NOMINATIONS FOR 1954

President	Bender B. Kneisley, Hagerstown
Vice-Presidents	E. Paul Knotts, Denton Ernest I. Cornbrooks, Jr., Baltimore Ralph G. Hills, Baltimore
Secretary	Everett S. Diggs, Baltimore
Treasurer	J. Albert Chatard, Baltimore
Councilors	A. Talbott Brice, Jefferson (1956) Harry C. Hull, Baltimore (1956) W. Oliver McLane, Jr., Frostburg (1956) W. Glenn Speicher, Westminster (1956)
Delegate to American Medical Association	Howard M. Bubert, Baltimore (1954, 1955)
Alternate Delegate to American Medical Association	Whitmer B. Firor, Baltimore (1954, 1955)
Committee on Scientific Work and Arrangements	Beverley C. Compton, *Chairman*, Baltimore William L. Garlick, Baltimore Edwin H. Stewart, Jr., Baltimore
Library Committee	E. T. Lisansky, Baltimore (1958)
Finney Fund Committee	Herbert E. Wilgis, Baltimore (1958)
Board of Medical Examiners	Henry T. Collenberg, Baltimore (1957) Samuel McLanahan, Baltimore (1956) (to fill unexpired term of Edward M. Hanrahan, Jr., deceased) Norman E. Sartorius, Jr., Pocomoke City (1957)

Nominating Committee

Melvin B. Davis, *Chairman*, Dundalk
Leslie E. Daugherty, Cumberland
Albert E. Goldstein, Baltimore
Harry C. Hull, Baltimore
Harold B. Plummer, Preston

Dr. Pincoffs asked for nominations from the floor. There were no nominations from the floor. Dr. Pincoffs announced, therefore, that the nominations are closed and the election takes place at the THIRD SESSION of the House of Delegates (Wednesday, April 29th, at 9:30 a.m.) at the Deutsches Haus, Second Floor auditorium, WITH THE EXCEPTION of the Board of Medical Examiners, which takes place at 12:00 noon, in Osler Hall on *WEDNESDAY, April 29th.* All members who are in good standing are eligible to vote for the Board of Medical Examiners.

Dr. W. O. McLane, Jr., Allegany-Garrett County, moved that a special assessment of ten dollars ($10.00) be levied on all active, full dues paying members of the Faculty for 1953. This was subsequently amended by Dr. Arthur O. Wooddy of Charles County stipulating that this assessment should be collectable by July first, 1953. The amendment evoked considerable discussion from the floor, but was carried by an overwhelming majority vote.

Dr. Waldo B. Moyers, Prince George's County, presented a recommendation with reference to the contemplated change in the By-Laws, Chapter II, Dues and Assessments. It was recommended that the By-Law relating to Dues and Assessments, not be voted on at this meeting, but that the President appoint a Committee of five members made up of County and City Delegates to confer with the Committee on Constitution and By-Laws in the study of this problem and to present a realistic solution not less than sixty (60) days before the Semiannual Meeting in 1953. The recommendation was unanimously adopted.

The meeting adjourned at 5:00 p.m.

Respectfully submitted,
George H. Yeager, M.D., *Secretary*

REPORT OF THE RESOLUTIONS COMMITTEE

Mr. President and Members of the House of Delegates:

In conformity with the Constitution and By-Laws, the President appointed the following Resolutions Committee: Dr. William D. Noble, Chairman, Easton, Dr. Charles R. Austrian, Baltimore, Dr. Robert V. Campbell, Hagerstown, Dr. F. Ford Loker, Baltimore, and Dr. M. C. Porterfield, Hampstead.

After reviewing the attached Resolutions which were received by the Committee, the following action was taken by the Resolutions Committee:

1. The Resolution from the Montgomery County Medical Society, recommending that the Medical and Chirurgical Faculty request Governor Theodore R. McKeldin to give consideration to the appointment of a practicing physician from one of the counties of Maryland to fill the vacancy in the membership of the State Board of Health, created by the death of Dr. T. S. Cullen was approved by the Resolutions Committee. Following is the Resolution:

WHEREAS, a vacancy exists in the membership of the State Board of Health, because of the death of Dr. Thomas S. Cullen, a member of the Board for many years, and

WHEREAS, the present membership of the State Board of

Health does not include a practitioner of medicine from the Counties of Maryland, and

WHEREAS, it is believed that the work of the State Department of Health will be benefitted and strengthened if a practicing physician from the Counties is included in the membership of the State Board of Health, therefore

BE IT RESOLVED, that the House of Delegates of the Medical and Chirurgical Faculty request Governor Theodore R. McKeldin to give consideration to the appointment of a practicing physician from the Counties of Maryland in filling the present vacancy in the membership of the State Board of Health. Submitted by L. Marshall Cuvillier, M.D., Secretary, for the Montgomery County Medical Society.

2. The Resolution submitted by the Maryland Society of Pathologists, requested that a pathologist be included in the nominations for membership on the Board of Medical Examiners of Maryland. It is the opinion of the Committee that this Resolution should be referred to the Council of the Medical and Chirurgical Faculty for action. Following is the Resolution:

It is the studied opinion of the Members of the Maryland Society of Pathologists, Inc. that, whereas clinical pathology and pathologic anatomy are an integral part of the examination given by the Maryland State Board of Medical Examiners, it is recommended for your consideration that a pathologist be included in the nominations made by the Council for membership on the Maryland State Board of Medical Examiners. Submitted by Tobias Weinberg, M.D., Secretary-Treasurer, for the Maryland Society of Pathologists.

3. Resolutions (2) from the Anne Arundel County Medical Society in reference to the "Doctor Draft" Law (Public Law #779) were disapproved, and the Committee approved the one submitted by Dr. R. Walter Graham, Jr. Following are the Resolutions:

RESOLUTION #1. *RESOLVED, that the "Doctor Draft" Law (Public Law #779), be revised to provide that physicians, who have not reached their 51st birthday, be divided into two groups;*

Group A—*those physicians never having military service, these men to be called according to age, the youngest being called first.*

Group B—*those physicians who have had military service since September 15, 1940; these men to be called according to the length of military service, those with the least service being called first.*

Group B *shall not be called until Group A is completely exhausted.*

RESOLUTION #2. *RESOLVED, that this draft law (Public Law #779), being a special draft law for professional people, should be taken out of the hands of local Selective Service Boards and put in the hands of a special Selective Board, one for each county or medical society district. This special Selective Service Board shall consist of 8 members, as follows: two laymen, three doctors of medicine, two doctors of Dentistry and one doctor of Veterinary Medicine.*

BE IT FURTHER RESOLVED, that copies of these resolutions be sent to the following: The Congressman from Anne Arundel County; The U. S. Senators from Maryland; The Medical and Chirurgical Faculty. Submitted by J. Howard Beard, M.D., Secretary-Treasurer, for the Anne Arundel County Medical Society. (Resolution disapproved by Committee.)

* * * * *

The House of Delegates of the Medical and Chirurgical Faculty hereby resolves that the present Doctors Draft Law, Public Law #779, should be extended by the Congress for two years, beginning from July 1, 1953.

IT IS FURTHER RESOLVED, that the $100.00 a month bonus incentive pay offered by the present Law should be continued and that the period of service for those professional men who have previously served in the military forces for twelve months since receiving their degree in their specialty should be reduced from twenty-four to seventeen months of further military duty.

IT IS FURTHER RESOLVED, that those professional men who have served twelve months of military duty since June 25, 1950, should not be recalled for service within the immediate future.

BE IT FURTHER RESOLVED, that a copy of this Resolution be sent to all members of the Congress representing the State of Maryland. Submitted by R. Walter Graham, Jr., M.D.

4. The Resolution from the Dorchester County Medical Society, recommending that a fund be established in the State Office of the Medical and Chirurgical Faculty which would be available for needy physicians, was approved in principle with the recommendation that the Chair or President appoint a committee to investigate the need for it, and if the Committee finds it feasible to raise such a fund, to report the findings to the House of Delegates for consideration of the original Resolution. Following is the resolution:

RESOLVED, that our Delegate to the State Society be instructed to suggest at the Annual Meeting in April, that a fund be established in the State Office of the Medical and Chirurgical Faculty which would be available for needy physicians. This was duly seconded and passed. Submitted by W. H. Hanks, M.D., Delegate, for the Dorchester County Medical Society.

Respectfully submitted,
William D. Noble, M.D., *Chairman*
Charles R. Austrian, M.D.
Robert V. Campbell, M.D.
F. Ford Loker, M.D.
M. C. Porterfield, M.D.

THIRD SESSION

Wednesday, April 29, 1953, 9:30 a.m.

The 206th meeting of the House of Delegates was called to order by the President, Dr. Maurice C. Pincoffs, at 9:30 a.m. in the Deutsches Haus, 1212 Cathedral Street, Baltimore.

The roll call was by registration and the following members were present: Doctors Conrad Acton, E. Cowles Andrus, D. F. Bartley, O. H. Binkley, J. W. Bird, Helen Bowie, Otto C. Brantigan, Read N. Calvert, R. V. Campbell, F. E. Chatard, J. A. Chatard, T. A. Christensen, B. J. Cohen, M. B. Davis,

E. S. Diggs, R. C. Dodson, C. Reid Edwards, W. L. Etienne, J. S. Fenby, Whitmer B. Firor, P. H. Futcher, Wilson Grubb, W. H. Hanks, J. M. Haws, J. G. Howell, Hugh J. Jewett, E. L. Jones, J. R. Karns, H. F. Klinefelter, Jr., J. H. M. Knox, III, D. B. Grove, H. R. Mann, Jr., W. K. Mansfield, J. T. Marsh, W. O. McLane, Jr., H. B. McNally, C. W. Mitchell, Z. R. Morgan, W. D. Noble, E. R. Novak, T. R. O'Rourk, J. W. Parsons, M. C. Porterfield, N. E. Sartorius, Jr., R. T. Shackelford, W. K. Waller, H. N. Ward, W. W. Welsh, A. F. Whitsitt, A. O. Wooddy, T. E. Woodward and G. H. Yeager.

The minutes of the previous meeting, held on Tuesday, April 28, 1953, were dispensed with upon appropriate motion.

The following officers, on proper nomination, were unanimously elected:

President	Bender B. Kneisley, Hagerstown
Vice-Presidents	E. Paul Knotts, Denton Ernest I. Cornbrooks, Jr., Baltimore Ralph G. Hills, Baltimore
Secretary	Everett S. Diggs, Baltimore
Treasurer	J. Albert Chatard, Baltimore
Councilors	A. Talbott Brice, Jefferson (1956) Harry C. Hull, Baltimore (1956) W. Oliver McLane, Jr., Frostburg (1956) W. Glenn Speicher, Westminster (1956)
Delegate to American Medical Association	Howard M. Bubert, Baltimore (1954, 1955)
Alternate Delegate to American Medical Association	Whitmer B. Firor, Baltimore (1954, 1955)
Committee on Scientific Work and Arrangements	Beverley C. Compton, *Chairman*, Baltimore William L. Garlick, Baltimore Edwin H. Stewart, Jr., Baltimore
Library Committee	E. T. Lisansky, Baltimore (1958)
Finney Fund Committee	Herbert E. Wilgis, Baltimore (1958)

Dr. Pincoffs announced that the election of members to the Board of Medical Examiners would take place today, at 12:00 noon, in Osler Hall, 1211 Cathedral Street.

Dr. A. Austin Pearre, Chairman of the Committee on Constitution and By-Laws, reviewed the proposed amendments to the Constitution and By-Laws as presented to the House of Delegates in its first session, April 28, 1953. (See pages 421 to 422 for action.)

Article VIII. (See page 458.)
Section 2. Sessions and meetings—approved.

Chapter I—Membership. (See page 460.)
Section 4. Emeritus members—approved.

Chapter VII. (See page 459.)
Section 6. (c) As presented by the Constitution and By-Laws was lost by a majority vote. A modification of this amendment, as proposed by Dr. Welsh, was carried by unanimous vote. In the proposed amendment, Chapter 9, Section 9, the words "each subsequent year to and including" are to be struck out. (See page 460.)

Chapter VIII

Section 1. (See page 459.) Standing Committees. Approved.

Section 8. (See page 459, 460.) Approved. The following additional paragraph as proposed by Dr. Etienne was lost: "The provisions of this section shall not be in effect against Component Society members providing such Society shall have in effect a regularly constituted Professional Conduct or Grievance Committee unless referred to the Faculty Committee by the constituent society."

Section 10. (See page 460.) Approved.

Chapter IX
Section 9. (See page 460.) As presented by the Constitution and By-Laws Committee was lost. A modification presented by Dr. Welsh eliminating the words "each subsequent year to and including" was unanimously endorsed.

Dr. Chesney made some brief comments on the financial difficulties of the County Medical Care Program. He explained that the budget had been cut by $100,000.00. The Council on Medical Care requested the support of the members of the House of Delegates with the hope that they will express their opinion to their appropriate State legislators. Dr. Marsh and Dr. Bird supported the remarks of Dr. Chesney. Dr. Futcher raised the question as to whether a Resolution with reference to the problem would be helpful in obtaining additional money. Dr. Chesney stated in his opinion such an action was not indicated at this time.

Dr. Klinefelter presented the following Resolution:

The National Arthritis and Rheumatism Foundation has for the last five years been promoting research, education, and treatment in the field of the rheumatic diseases.

The Maryland Chapter of the Arthritis and Rheumatism Foundation has been conducting clinics in almost all the counties of the State for the last year, in cooperation with the County Medical Societies. Only patients referred by the local physicians are seen and only a consultation type of service is rendered, without charge and preferably with the patient's physician in attendance.

Be it resolved that the House of Delegates endorse the service being rendered by the Maryland Chapter of the Arthritis and Rheumatism Foundation and encourage the doctors of the counties to refer their patients to the county clinics.

This Resolution regarding County Clinics evoked considerable discussion from the floor. Drs. Welsh, Campbell, Acton, Shackelford, and Wooddy, made comments with reference to the activities of the group. Dr. Welsh questioned the advisability of endorsing a multiplicity of organizations. Dr. Klinefelter stated that there would not be an Arthritic Clinic established in any County without prior County Medical Society approval. Dr. Shackelford stated that if permission for the establishment of clinics was obtained at the local level, he did not see any reason for presentation to the House of Delegates for general approval. The Resolution was lost by majority vote.

Dr. Theodore Woodward made a brief announcement with reference to the Semiannual Meeting and the necessity of making reservations.

Dr. C. Reid Edwards briefly discussed the structure of the State Society and emphasized the necessity for the development of a strong organization with sound financial support.

There being no further business to come before the meeting, adjournment followed at 10:45 a.m.

Respectfully submitted,
George H. Yeager, M.D., *Secretary*

GENERAL MEETING

Wednesday, April 29, 1953

12:00 Noon, Osler Hall

Election of State Board of Medical Examiners of Maryland

The election for three new members of the Board of Medical Examiners of Maryland was held at 12:00 noon, Wednesday, April 29, 1953, one of whom is to fill the unexpired term of Dr. Edward M. Hanrahan, Jr., deceased. The meeting was called to order by the President, Dr. Maurice C. Pincoffs. Three nominations were introduced from the House of Delegates, which nominated Drs. Henry T. Collenberg, Samuel McLanahan, and Norman E. Sartorius, Jr. Nominations were requested from the floor.

There being no additional nominations, it was moved. seconded, and unanimously carried, that the following be elected to the Board of Medical Examiners of Maryland: Henry T. Collenberg, M.D., Baltimore, (1957), Samuel McLanahan, M.D., Baltimore, (1956) (to fill unexpired term of Edward M. Hanrahan, Jr., deceased) and Norman E. Sartorius, Jr., M.D., Pocomoke City, (1957).

NEW EXHIBITS READY FOR SHOWINGS

AMA News Notes, Volume 2, No. 7

With county fair time just around the corner, the AMA's Bureau of Exhibits announces the completion of two new exhibits . . . one on nutrition and the other a portable version of "Health Today," the popular display showing that the American people enjoy better health today than ever before. If you want additional information, write to the Bureau of Exhibits, A. M. A., 535 N. Dearborn Street, Chicago 10, Illinois

* * * *

NEW FILM RATES "A" AS PR AID

AMA News Notes, Volume 2, No. 7

Democracy in action exemplified in a new motion picture film—"A Citizen Participates"—shows how members of a rural community can work together to get a physician. Produced by the Centron Corporation and cleared by the American Medical Association, this film should be a valuable public relations tool for state and county medical societies. The film may be obtained on loan from Young America Films, Inc., for showings to various organizations and business groups in your community. Running time—27 minutes. For further information contact: Young America Films, Inc., 18 East 41st Street, New York 17, N. Y.

* * * *

IV CONGRESS OF THE PAN AMERICAN MEDICAL WOMEN'S ALLIANCE

The IV Congress of the Pan American Medical Women's Alliance will be held at the Beekman Towers Hotel, First Avenue and 49th Street, New York, from September 24 through October 1, 1953. The morning hours will be given over to a scientific program of general interest. There will be round-table luncheon discussions with leaders speaking Spanish and English. Through the sponsorship of leading New York medical women those interested in a special field will have opportunities to attend clinics of their choice. The Medical Women's Association of New York is serving as hostess and planning a most delightful program, including tours of the New York Hospital-Cornell Medical Center and Columbia-Presbyterian Medical Center, a boat trip around Manhattan Island, tour and luncheon at the United Nations, visits to Radio City and the Empire State Building, and a drive to Hyde Park. Hotel reservations should be made direct with the hotel.

REPORTS[1, 2]

To the House of Delegates

SECRETARY

Mr. President and Members of the House of Delegates:

There is a total membership in the Medical and Chirurgical Faculty of 2,430.[3] Statistical report, see page 428. By January 31, 1953, every member in the following Component Societies had paid his dues: Anne Arundel, Calvert, Caroline, Cecil, Charles, Dorchester, Howard, Kent, Queen Anne's, St. Mary's, Somerset, Talbot, Washington and Wicomico.

More than one-half of the membership has paid the 1953 American Medical Association dues. The following are the statistics to April 7, 1953:

Baltimore City paid through 1953	775	
Counties paid through 1953	503	
	—	1,278
Baltimore City paid through 1952	174	
Counties paid through 1952	133	307
		1,585

This is my last annual report as Secretary of the Medical and Chirurgical Faculty. During the time I have been in office, it has been stimulating to see the active part the Medical Profession assumes in the State to improve the health of its citizens. The Association never remains static as the reports of the other Officers and Committees indicate.

It is of interest that the Faculty Building is being used a great deal more each year, not only for its own activities, but those of other groups allied to medicine. As you know, the regular meetings of the Baltimore City Medical Society, its Sections and Committees convene here, but among the other groups who have used the building are several of the hospitals for their joint staff meetings, Advisory Committees to the Medical Care Committee of the Maryland State Planning Commission, symposia under the auspices of the joint Bar Association and Medical and Chirurgical Faculty, Sinai Hospital Alumni group, Civil Defense, the Baltimore Psychoanalytic Society and the Maryland Society for Medical Research. The Baltimore City Woman's Auxiliary holds its meetings in Osler Hall. The Nurse Recruitment project of the Woman's Auxiliary is holding an all day meeting in Osler Hall. In the Library a tea for a regional Medical Library Association group was held on April 11, 1953. The rooms on the third floor are being used gratis for offices by the Committee on Medical Care of the State Planning Commission and the Committee for the Study of Pelvic Cancer. These functions greatly increase the work of those taking care of the maintenance of the building.

One of the Trimble lecturers for the Annual Meeting, 1952, failed to file a copy of his manuscript with the Faculty. This has always been a requisite in regard to all lectureships under the special funds designated for this purpose. The Chairman of Council has referred to this and the action of the Council in his report. The viewpoint of the Editorial Board not to publish this paper in the Journal unless edited by the author was upheld, and the Secretary was so instructed.

As a result of the House of Delegates action last April in approving the recommendations of the Secretary, the Small Hall has been redecorated and converted into an office for the staff. With new lighting, telephones, better ventilation and more space between desks, the staff finds the physical working conditions improved. It is hoped that every member will take the time while attending these meetings to "drop in" and see the improved office facilities.

When funds are available, other improvements will be made. The three small offices need redecorating. These will be utilized in various ways for small committee meetings when the Friedenwald Room is not available, and for Journal, Mimeographing, switchboard, etc. Even now there isn't enough space to work efficiently. Desks, files and other new office equipment are needed.

I would like to express to Mr. Kirkman and the Staff, appreciation for their work and cooperation. It is timely to point out that the office staff realizes that efficiency is handicapped because of an insufficient number of employees. Under present conditions it is impossible to keep current business of the organization up to date. This is due to lack of funds to employ additional stenographers. The salaries of the present staff are not commensurate with the interest shown and work accomplished, nor with present day salary standards. It is expedient to overcome these handicaps if we are to have a Medical Association which is to keep abreast of the times, and which can meet the challenge of the problems with which it is confronted.

Respectfully submitted,
George H. Yeager, M.D., *Secretary*

---

[1] A summary of these reports, which were submitted by the Officers, Chairman of the Council, A.M.A. Delegates, and the Chairmen of the Committees, was mailed to every Delegate and the President and Secretary of each Component Society prior to the meeting of the House of Delegates on Monday, April 27, 1953.

[2] For Resolutions, Reports, etc. submitted on Tuesday, April 28 and Wednesday, April 29, 1953, see pages 421 to 426.

[3] Membership Roster for March 31, 1952 to March 31, 1953, published in May 1953 Journal.

Secretary's Report

April, 1953

MEMBERSHIP 1952	MEMBERSHIP 1953	PAID IN ADVANCE	COUNTIES	NEW MEMBERS	DECEASED	RESIGNED	REMOVED	DROPPED
77	78	70	Allegany-Garrett County Medical Society	5	3		1	
52	56	56*	Anne Arundel County Medical Society	7	1	1	1	
154	153	137	Baltimore County Medical Society	9	3		7	
1339	1336	1223	Baltimore City Medical Society, Active	82	35	8	42	
89	92	63	Baltimore City Medical Society, Associate	16		5	8	
11	11	11*	Caroline County Medical Society	1	1			
6	6	6*	Calvert County Medical Society					
34	37	32	Carroll County Medical Society	5			2	
18	20	20*	Cecil County Medical Society, Active	2				
11	7	7*	Cecil County Medical Society, Associate	2		4	2	
15	15	15*	Charles County Medical Society	1			1	
20	23	23*	Dorchester County Medical Society	4	1			
50	53	52	Frederick County Medical Society	4			1	
29	31	30	Harford County Medical Society	3	1			
9	10	10*	Howard County Medical Society	1				
10	13	13*	Kent County Medical Society	3				
158	171	163	Montgomery County Medical Society, Active	20		5	2	
48	9	6	Montgomery County Medical Society, Associate	6		45		
72	78	64	Prince Georges County Medical Society, Active	8	1	1		
27	29	9	Prince Georges County Medical Society, Associate	3		1		
9	10	10*	Queen Anne County Medical Society	1				
14	15	15*	St. Mary's County Medical Society	1				
10	13	13*	Somerset County Medical Society	3				
23	28	28*	Talbot County Medical Society	6	1			
70	72	72*	Washington County Medical Society	4	2			
42	49	49*	Wicomico County Medical Society	8		1		
13	14	12	Worcester County Medical Society, Active	1				
1	X		Worcester County Medical Society, Associate			1		
40	41	37	Non-resident membership	5	3	1		
2451	2470	2245		211	52	73	67	

ACTUAL GAIN—19

GAIN—Active Members	....	57
Non-resident Members	....	1
		58
LOSS— Associate Members	....	39
Gain	....	19

TREASURER

Mr. President and Members of the House of Delegates:

You will have copies of the financial report of the Treasurer in detail showing receipts and expenditures on page 429.

I wish to emphasize now as in the past that our dues are not sufficient to carry on the work of the Faculty, which work has grown beyond all our anticipated wants. Mr. Kirkman and I recently in a report to the Counties and City Society, showed the needs of the Faculty to do our work properly and the great need of extra office help. When this condition was called to the attention of the Council at its last meeting, it was decided that an additional $10.00 in dues be required of all members, City and State.

This increase in dues is essential, and can only be understood if at different times when convenient to you, you spend a little while (a few hours), in *your* building and in *your* offices and library to see at first hand how much must be done and is being done by your staff for *your* various needs.

Come, see, inquire, and then at first hand information, you will better understand your Faculty. At a distance, without this knowledge you will never be able to realize how much *you owe* for all that is done for *you.*

Respectfully submitted,

J. ALBERT CHATARD, M.D., *Treasurer*

THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND
Baltimore, Maryland

GENERAL FUND—INCOME AND EXPENSE STATEMENT
For Year Ended December 31st, 1952

Income				
Dues				
Baltimore City Dental Society		$1,407.00		
Baltimore City Medical Society		37,574.50		
County Medical Societies		15,699.50		
Physiotherapists		3.00		
Halls and Offices—Baltimore City Medical Society		400.00		
Halls and Offices—Other		4,830.00	$59,914.00	
Meetings—Annual and Semi-Annual—Exhibits			2,750.00	
Women's Auxiliary—For Salaries			100.00	
Baltimore City Medical Society				
For Salaries		$3,100.00		
For New Equipment		650.00	$3,750.00	
American Medical Association—For General Purposes			383.57	
Transfers from Consolidated Fund—Income Funds				
Josiah S. Bowen Fund—For General Purposes		$579.39		
Frank C. Bressler Fund—For General Purposes		121.79		
Charles M. Ellis Fund—For General Purposes		1,172.50		
Osler Endowment Fund—For General Purposes		93.89		
Osler Testimonial Fund—For General Purposes		286.73		
John Ruhrah Fund				
For Salaries	$300.00			
For General Purposes	1,747.04	$2,047.04		
Hiram Woods Fund—For General Purposes		148.87	$4,450.21	
Transfer from Contingent Fund—Income—For General Purposes			261.00	
Miscellaneous Income—Sale of Waste Paper			32.00	
Total Income				$71,640.78
Expense				
American Medical Association Educational Fund Committee Expense			$29.88	
Accounting Fees—Portion			390.00	
Communication Expense—Postage, Telephone and Telegraph			2,803.92	
Contributions—National Society for Medical Research			50.00	
Fuel			2,323.59	
Gas, Electricity and Water			2,120.70	
Household and Janitorial Supplies			479.23	
Insurance			996.87	
Interest Paid			213.50	
Journal Expense		$18,062.81		
Less—Subscription Income		17,725.34	$337.47	
Legal Fees			625.00	
Legislative Committee Expense			68.22	
Library Account—Supplies and Expense			55.87	
Maintenance of Property			2,319.57	
Maryland Unemployment Insurance			81.28	
Federal Unemployment Insurance			94.36	
Social Security Tax			1,285.45	

Meetings—Annual and Semi-Annual	4,847.85	
Miscellaneous Expense	2,426.64	
Purchase of Equipment	2,206.75	
Office Supplies	1,443.56	
Printing	1,384.31	
Salaries	44,575.80	
Travel	713.07	
Total Expense		$71,872.89
December 31st, 1952—Excess of Expense over Income		232.11

GENERAL FUND—DEFICIT ACCOUNT

January 1st, 1952—Balance to Debit of Account	$5,947.51
Addition	
Excess of Expense over Income—For Year Ended December 31st, 1952—Exhibit B	232.11
December 31st, 1952—Balance to Debit of Account	6,179.62

CONSOLIDATED FUND—INCOME FUNDS—INCOME AND EXPENSE STATEMENT

For Year Ended December 31st, 1952

Income			
Income from Consolidated Fund Investments			
Bonds			
United States Government and Municipal	$917.73		
Public Utility, Railroads, etc.	1,094.90	$2,012.63	
Stocks			
Common	$8,699.68		
Preferred	392.19	$9,091.87	
Interest Special Savings Account—Maryland Trust Company		16.46	
		$11,120.96	
Less—Agencies Fees		442.40	
Net Income from Investments			$10,678.56
Interest on Savings Accounts—Maryland Trust Company			193.30
Total Income			$10,871.86
Expense			
Special Purposes		$539.73	
Library Purposes		4,247.70	
General Purposes—Mimeographing		160.00	
Transfers to General Fund			
Salaries	$300.00		
General Purposes	4,150.21	$4,450.21	
Total Expense			$9,397.64
December 31st, 1952—Excess of Income over Expense			$1,474.22

CONSOLIDATED FUND—INCOME FUNDS BALANCE

January 1st, 1952 to December 31st, 1952

January 1st, 1952—Balance to Credit of Account	$25,173.97
Additions	
Excess of Income over Expense—For Year Ended December 31st, 1952	1,474.22
December 31st, 1952—Balance to Credit of Account	$26,648.19

CONSOLIDATED FUND—INCOME FUNDS
RECEIPTS, EXPENDITURES AND BALANCES

January 1st, 1952 to December 31st, 1952

		RECEIPTS				EXPENDITURES					BALANCES—DECEMBER 31, 1952 REPRESENTED BY					
			Income from Investments									Additions		Deductions		
FUND	BALANCES JANUARY 1ST, 1952	Interest on Savings Accounts	Per Cent	Amount	SUB-TOTAL	Special Purposes	Library Purposes	General Purposes	Transfer to General Fund	BALANCES DECEMBER 31ST, 1952	Savings Accounts Balances	Undeposited Receipts	Investment	Due Principal Fund	Due General Fund	Balances December 31st, 1952
Baker	$79.33	$.70	.47	$50.19	$130.22		$32.70			$97.52	$87.08	$10.44				$ 97.52
Barker, Lewellys F.	91.75	.90	.31	33.10	125.75		4.50			121.25	114.37	6.88				121.25
Bowen, Josiah S.	731.32	18.35	6.85	731.48	1,481.15			160.00	579.39	741.76	1,218.97	152.09		629.30		741.76
Bressler, Frank C.	151.10	2.05	1.44	153.76	306.91				121.79	185.12	153.15	31.97				185.12
Cordell, Eugene Fauntleroy	4,525.10	30.00	3.03	323.56	4,878.66	7.36				4,871.30	4,804.02	67.28				4,871.30
Ellis, Charles M.	None	None	10.98	1,172.50	1,172.50				1,172.50	None	None	243.79			243.79	None
Finney, John M. T.	1,351.37	17,20	6.79	725.08	2,093.65		681.71			1,411.94	1,261.18	150.76				1,411.94
Frick, William F.	3,236.07	29.35	11.74	1,253.67	4,519.09		1,534.86			2,984.23	2,723.56	260.67				2,984.23
Friedenwald, Julius	159.00	2.00	.59	63.00	224.00	108.25				115.75	102.65	13.10				115.75
Harlan, Herbert	60.55	.50	.66	70.48	131.53		12.60			118.93	104.28	14.65				118.93
McCleary, Standish	72.62	.70	.62	66.21	139.53		10.00			129.53	115.76	13.77				129.53
Osler Endowment	695.09	9.90	1.11	118.54	823.53				93.89	729.64	704.99	24.65				729.64
Osler Testimonial	953.38	13.55	6.78	724.01	1,690.94		230.89		286.73	1,173.32	1,022.78	150.54				1,173.32
Ruhrah, John	10,058.83	30.00	41.31	4,411.31	14,500.14		1,601.58		2,047.04	10,851.52	4,884.30	917.22	5,050.00			10,851.52
Stokes, William Royal	1,801.20	22.60	3.46	369.47	2,193.27		138.86			2,054.41	1,977.59	76.82				2,054.41
Trimble, Isaac Ridgeway	892.62	11.25	2.10	224.25	1,128.12	424.12				704.00	657.37	46.63				704.00
Woods, Hiram	314.64	4.25	1.76	187.95	506.84				148.87	357.97	318.89	39.08				357.97
Totals	$25,173.97	$193.30	100.00	$10,678.56	$36,045.83	$539.73	$4,247.70	$160.00	$4,450.21	$26,648.19	$20,250.94	$2,220.34	$5,050.00	$629.30	$243.79	$26,648.19

CONSOLIDATED FUNDS—AMOUNTS IN PRINCIPAL FUND

December 31st, 1952

FUND	PURPOSE	AMOUNT
Baker	Books on Materia Medica	$870.50
Barker, Lewellys F.	Library	520.00
Bowen, Josiah S.	General	11,807.29
Bressler, Frank C.	General	2,400.00
Cordell, Eugene Fauntleroy	Relief of Widows and Orphans	4,847.97
Ellis, Charles M.	General	6,000.00
Finney, John M. T.	Books, Journals and Lectureships on Surgery	11,181.32
Frick, William F.	Maintenance Frick Library, Purchase Books and Journals	20,000.00
Friedenwald, Julius	Maintenance of Friedenwald Room	1,000.00
Harlan, Herbert	Books on Ophthalmology	1,015.00
McCleary, Standish	Lectureships and Books on Pathology	1,000.00
Osler Endowment	Permanent Endowment for Books and Buildings, by request of Dr. Osler	1,860.98
Osler Testimonial	Medical Books and Maintenance of Osler Hall	10,316.99
Ruhrah, John	Library, Books and Journals, etc.	54,317.86
Stokes, William Royal	Lectureships and Books on Bacteriology	4,119.59
Trimble, Isaac Ridgeway	Lectureships Only	3,519.25
Woods, Hiram	General	3,000.00
		$137,776.75

FUNDS INVESTED IN FIXED ASSETS—PRINCIPAL

December 31st, 1952

January 1st, 1952—Balance to Credit of Account		$391,739.71
Additions		
January 18th, 1952—One 55″ Grey Steel Secretarial Desk	$167.00	
January 22nd, 1952—Two 11″ Underwood Typewriters	293.90	
February 8th, 1952		
One 55″ Grey Steel Secretarial Desk	167.00	
One Grey Steel Four Drawer Letter Size File	83.50	
March 26th, 1952—Installation of Ventilating System	777.90	
April 19th, 1952—One Ekotape Recorder—Complete	638.00	
December 30th, 1952—One Model XXX Electrolux Vacuum Cleaner	79.45	$2,206.75
December 31st, 1952—Balance to Credit of Account		$393,946.46

BUILDING FUND—PRINCIPAL

January 1st, 1952 to December 31st, 1952

January 1st, 1952—Balance to Credit of Account			$54,369.05
Additions			
Payments on Pledges		$5,602.87	
Interest			
Savings Account	$13.87		
United States Government Bonds	986.34	$1,000.21	$6,603.08
			$60,972.13
Deductions			
Bond Premium		12.50	
Campaign Expenses		194.30	
Capital Expenditure—New Office—Flooring, Ceiling and Carpentry Work		613.28	$820.08
December 31st, 1952—Balance to Credit of Account			$60,152.05

CONTINGENT FUND

January 1st, 1952 to December 31st, 1952

INCOME

January 1st, 1952—Balance to Credit of Account		$545.90
Additions		
Dividends	$231.00	
Interest		
United States Government Bonds	125.00	
Savings Account	9.00	$365.00
		$910.90
Deductions		
Portion of Accounting Fees	95.00	
Agency Fee	27.25	
Transfer to General Fund	261.00	$383.25
December 31st, 1952—Balance to Credit of Account		$527.65

PRINCIPAL

January 1st, 1952—Balance to Credit of Account	$9,921.30
Addition	
December 23rd, 1952—Sale of 165 rights Consolidated Gas, Electric Light and Power Company	90.75
December 31st, 1952—Balance to Credit of Account	$10,012.05

NELLIE N. COWLES BEQUEST FUND

January 1st, 1952 to December 31st, 1952

INCOME

January 1st, 1952—Balance to Credit of Account	$25.00
Addition	
Interest—United States Government Bonds	25.00
	$50.00
Deduction	
Agency Fee	2.50
December 31st, 1952—Balance to Credit of Account	$47.50

PRINCIPAL

January 1st, 1952—Balance to Credit of Account	$1,000.00
No changes during year	—
December 31st, 1952—Balance to Credit of Account	$1,000.00

MEDICAL ANNALS FUND

January 1st, 1952 to December 31st, 1952

PRINCIPAL

January 1st, 1952—Balance to Credit of Account	$774.33
Addition	
Interest on Savings Account	7.60
December 31st, 1952—Balance to Credit of Account	$781.93

HARVEY G. BECK LECTURESHIP FUND

January 1st, 1952 to December 31st, 1952

PRINCIPAL

January 1st, 1952—Balance to Credit of Account	None
Addition	
November 5th, 1952—Bequest—13 shares American Telephone and Telegraph Company	$1,998.55
December 31st, 1952—Balance to Credit of Account	$1,998.55

BALANCE SHEET—DECEMBER 31ST, 1952

ASSETS

General Fund			
Cash			
Maryland Trust Company	$359.48		
Petty Cash Fund	100.00	$459.48	
Due from Consolidated Fund—Income Funds			
Charles M. Ellis Fund	$243.79		
Special Savings Account	1.00	$244.79	
Total General Fund Assets			$704.27
Consolidated Fund—Income Funds			
Cash			
Maryland Trust Company	$20,250.94		
Undeposited Receipts	2,220.34		
Maryland Trust Company—Special Account	1.00	$22,472.28	
Investments—Maryland Medical Service, Inc.		5,050.00	
Total Consolidated Fund—Income Funds—Assets			$27,522.28
Consolidated Fund—Principal			
Uninvested Cash			
Held by Maryland Trust Company	$630.33		
Held by Mercantile Trust Company	195.33	$856.66	
Due from Josiah S. Bowen Fund—Consolidated Fund—Income Funds		629.30	

LIABILITIES AND FUNDS

General Fund			
Liabilities			
Designated Funds			
For Purchase of Dental Books	$5.84		
For Library Account—Books and Journals	40.24	$46.08	
Withholding Tax—December, 1952		537.81	
Note Payable—Maryland Trust Company—Due on Demand—Interest at 3½% per annum (Certain Securities of Consolidated Fund held as Collateral—See Letter)		6,000.00	
Prepaid Exhibit Fees		300.00	
Total General Fund Liabilities		$6,883.89	
General Fund Deficit		*6,179.62*	
Total General Fund Liabilities and Deficit			$704.27
Consolidated Fund—Income funds			
Liabilities			
Due to General Fund—From Charles M. Ellis Fund		$243.79	
Due to General Fund—From Special Savings Account		1.00	
Due to Consolidated Fund—Principal—From Josiah S. Bowen Fund		629.30	
Total Consolidated Fund—Income Funds—Liabilities		$874.09	
Consolidated Fund—Income Fund—Balances		26,648.19	
Total Consolidated Fund—Income Funds—Liabilities and Balances			$27,522.28
Consolidated Fund—Principal			
Designated Funds		$137,776.75	

Investments (Market Value as of January 1st, 1946 and additions at Cost)			
United States Government and Municipal Bonds	$38,040.85		
Public Utility and Railroad Bonds	22,552.06		
Preferred Stocks	10,446.75		
Common Stocks	104,432.98		
	$175,472.64		
Less—Reserve to bring Book Value of Securities down to Actual Cost	39,150.85	$136,321.79	
Total Consolidated Fund—Principal			$137,776.75
Funds Invested in Fixed Assets (No Depreciation Provided)			
Real Estate—Cost			
Property—1209–11–13 Cathedral Street—In Fee	$110,635.76		
Annex Property—1215–17 Cathedral Street—In Fee	19,118.95	$129,754.71	
Personal Property (Appraisal Figures at December 31st, 1949 and Additions at Cost)			
Library Books and Journals	$231,370.00		
Office, Library, Household Fixtures, Antiques and Museum Pieces	18,821.75		
Portraits	14,000.00	$264,191.75	
Total Funds Invested in Fixed Assets			$393,946.46
Forwarded			$559,949.76
Building Fund			
Cash—First National Bank			
Checking Account	$4,748.75		
Savings Account	66.04	$4,814.79	
Investments—Cost			
United States Government Bonds		55,337.26	
Total Building Fund			60,152.05
Contingent Fund—Income			

Total Consolidated Fund—Principal		$137,776.75
Funds Invested in Fixed Assets Principal	$393,946.46	
Total Funds Invested in Fixed Assets—Principal		393,946.46
		$559,949.76
Building Fund Principal	$60,152.05	
Total Building Fund—Principal		60,152.05
Contingent Fund—Income		

Cash—Maryland Trust Company		527.65	
Total Contingent Fund—Income			527.65
Contingent Fund—Principal			
Uninvested Cash—Maryland Trust Company		90.75	
Investments—Cost			
United States Government Bonds	5,000.00		
Common Stock	4,921.30	9,921.30	
Total Contingent Fund—Principal			10,012.05
Nellie N. Cowles Bequest Fund—Income			
Cash—Held by Maryland Trust Company		47.50	
Total Nellie N. Cowles Bequest Fund—Income			47.50
Nellie N. Cowles Bequest Fund—Principal			
Investments—Cost			
United States Government Bonds		1,000.00	
Total Nellie N. Cowles Bequest Fund—Principal			1,000.00
Medical Annals Fund			
Cash—Union Trust Company of Maryland		781.93	
Total Medical Annals Fund			781.93
Harvey G. Beck Lectureship Fund—Principal			
Investments—Cost			
Common Stock		1,998.55	
Total Harvey G. Beck Lectureship Fund—Principal			1,998.55
Total Assets			$634,469.49

Balance	527.65	
Total Contingent Fund—Income—Balance		527.65
Contingent Fund—Principal		
Principal	$10,012.05	
Total Contingent Fund—Principal		10,012.05
Nellie N. Cowles Bequest Fund—Income		
Balance	47.50	
Total Nellie N. Cowles Bequest Fund—Income—Balance		47.50
Nellie N. Cowles Bequest Fund—Principal		
Principal	1,000.00	
Total Nellie N. Cowles Bequest Fund—Principal		1,000.00
Medical Annals Fund		
Principal	781.93	
Total Medical Annals Fund		781.93
Harvey G. Beck Lectureship Fund—Principal		
Principal	1,998.55	
Total Harvey G. Beck Lectureship Fund—Principal		1,998.55
Total Liabilities and Funds		$634,469.49

CERTIFICATE

The Medical and Chirurgical Faculty of the State of Maryland,
1211 Cathedral Street, Baltimore 1, Maryland.

Gentlemen:

We have made a partial audit of the records in the office of the Treasurer of The Medical and Chirurgical Faculty of the State of Maryland, for the year ended December 31st, 1952. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

As a result of our work, we report to you, that in our opinion the Exhibits, together with the comments in this report, present fairly the financial position of the Faculty as of December 31st, 1952, and for the year ended on that date.

Respectfully submitted,
Wooden, Benson & Walton
Certified Public Accountants,
Members American Institute of
Accountants

COUNCIL

Mr. President and Members of the House of Delegates:

Under the Constitution and By-Laws of this Faculty, the Chairman is appointed annually by the Council. This year, which is the one that my term of office as a member of the Council expires, I had the honor to be again chosen to serve as a Chairman. Dr. E. C. Andrus was elected to the office of Vice-Chairman.

There were five Council meetings from April 1952 through February, 1953, with an average attendance of nineteen.

The Executive Committee met in regard to a few matters and in many instances telephone or mail memorandums were the medium used to carry on the business of the Council in the interim of meetings.

Contributions were made to the following: National Society for Medical Research. The Council felt that the Faculty could not contribute this time to the Middle Atlantic Regional Conference, the Conference of Presidents, and towards the Nurse Recruitment film which is the project of the Woman's Auxiliary to the Baltimore City Medical Society.

Dr. Albert E. Goldstein and members of his Finance Subcommittee of the New Building Committee, after careful study complied with the request of the Council that the conversion of the Small Hall on the first floor be turned into offices by taking care of the expense from the Building Fund. In the early part of December the offices were moved from their former location to the Small Hall and the working facilities are greatly improved. As soon as finances permit, we will endeavor to install some new office furniture, and other equipment. It is also anticipated, when funds are available, to redecorate the three small offices, having one where the switchboard is maintained, another to be furnished so it may be used for small meetings when committees are also meeting in the Friedenwald Room, and an office for the Editor of the Journal and office for the mimeographing.

Council recommended that the American Medical Association bills be mailed out from the Faculty office in December when bills and bill notices were sent to individual members. This procedure was followed for the 1953 bills.

The Council ratified the action in approving and endorsing the film, "Cheers for Chubby" produced by the Metropolitan Life Insurance Company, which was shown in the motion picture theatres in Maryland, and the letter which was sent to each manager by the Metropolitan. The Executive Committee reviewed this film before giving its approval.

Dr. Chesney met with the Automobile Commissioner in reference to the Woman's Auxiliary Resolution regarding the re-evaluation of the physical fitness of automobile drivers. As a result of this interview with Mr. Thomas B. R. Mudd, the Council authorized that the Faculty should offer its services in furthering any attempt of the Commissioner of Motor Vehicles to present a statute to the Legislature for periodic health examinations.

The subject of certain changes being contemplated on the Medical Board of the State Industrial Accident Commission, whereby lawyers will supplant doctors has been discussed at several meetings. At this time, the Medical Board members are appointed from lists submitted by the respective Deans of the Johns Hopkins University Medical School and the University of Maryland School of Medicine and from the Medical and Chirurgical Faculty. A letter in opposition to the proposed changes was written to the Chairman of the Board and to a member of the Sobeloff Commission. In conformity with the Law, the Council recommended to Governor McKeldin the following names of which the Governor was to select one to serve on the Medical Board for Occupational Disease for the State Industrial Accident Commission: Dr. N. B. Herman, Dr. J. Sheldon Eastland and Dr. W. Kennedy Waller.

The term of office of each member of the Board is six years and Dr. N. B. Herman's term expired as of 1953. Prior to this year, the Governor has always appointed the first name on the list. These lists are not only submitted by the Faculty but also by the Deans of the two Medical Schools. I am sure that you all know that the Governor did not select Dr. N. B. Herman whose name was submitted by each of the above mentioned groups even though protests were sent to the Governor by the Deans of The Johns Hopkins University

School of Medicine and the Executive Committee of the Medical and Chirurgical Faculty.

At the April meeting of the House of Delegates the following Resolution was adopted: "Be it Resolved, by the Baltimore City Medical Society that a recommendation be made to the Medical and Chirurgical Faculty of the State of Maryland that it formulate a plan whereby incentives shall be provided of sufficient attraction to encourage an adequate distribution of general practitioners and specialists in areas in the State where they are needed." In order to fulfill the requisites of this Resolution, it was necessary to have a Committee to do the work. The Council empowered the President, Dr. Alan M. Chesney, to appoint such a Committee which was to report to the Council and House of Delegates. This Committee will make its report at the forthcoming meetings.

Dr. Waldo B. Moyers, Chairman, and members of the Committee for the Study of Certain Phases of Medical Economics, which was reactivated, were asked to continue their study regarding tax relief at the local level. Mr. G. C. A. Anderson, the Faculty's attorney, has been requested to assist the Committee.

Dr. Moyers discussed with Council his views at the December meeting which Mr. Anderson attended. Dr. Moyers is making a report to the House of Delegates.

Gus O. Caution, who has been an employee of the Faculty for 56 years, and who has not been well and only able to come in a few hours a day, is to be kept on his regular salary. When Gus completed 56 years in our employ, the Faculty joined with the Baltimore City Medical Society and the Board of Medical Examiners in taking recognition of his length of service at the Baltimore City Medical Society meeting on February 20, 1953.

Miss Pauline Duffield resigned as Librarian to assume a position as Librarian for the Texas State Medical Society. On the recommendation of the Library Committee, Miss Helen Wheeler and Mrs. Mary Berge, respectively, were employed as librarian and assistant librarian. The latter was to take the place of one of Miss Duffield's assistants who resigned. Other matters pertaining to the Library were presented for discussion by Dr. Krause. Some of these were acted on favorably and some are pending due to lack of Faculty funds.

On the basis of a report from Mr. Anderson, the Council disapproved of the publication of a fee schedule by a group in one of the counties.

The December and February meetings were supper meetings—Council convened at 4:00 p.m., adjourned from 6 to 7 o'clock for dinner, and reconvened at 7:00 p.m., adjourning when the business was completed—usually around ten o'clock.

Mr. Anderson attended the meeting on December 2, 1952, and advised the Council in several legal matters that were discussed at the meeting.

The concensus of opinion of the Council, on the basis of Mr. Anderson's feeling, on an inquiry regarding the incorporation of a group of doctors was that this is unethical.

Dr. R. W. Graham explained the contemplated changes in the Draft Law and in compliance with his request, wires were sent to the two Faculty delegates who were attending the House of Delegates meeting of the American Medical Association, urging them to support the contemplated change in the Law.

Several matters regarding the Woman's Auxiliary were discussed and decisions reached regarding these requests or problems.

Mrs. Harvey G. Beck has generously set up a fund in memory of her husband to be known as the "Harvey Grant Beck Memorial Lectureship" and the first address will be given at the Annual Meeting this year.

Dr. Walter D. Wise requested that as Dr. John Ruhräh had put a great deal of work and time into the Faculty and then left his money to the Faculty, that there be a fitting and more satisfactory memorial to him in the new building than the present Ruhräh Room. Council referred this suggestion as a recommendation to the New Building Committee.

Following are changes made by the Council regarding committees. Sesquicentennial Committee changed to the more appropriate name of New Building Committee. The Committee on Medical Service and Public Relations; Presidential Advisory Committee; and the Medical Care Campaign Committee were discontinued.

Due to the financial problems in relation to the salaries of the employees, the difficulty in obtaining new employees for the office for the amount the Faculty can afford to pay, the necessary expense for upkeep of the building, and rising costs, the Council requested the Committee on Constitution and By-Laws to prepare amendments to the By-Laws increasing the dues of all members by the sum of $10.00.

The Council has authorized, beginning in 1952, that the Transactions are to be published in the Maryland State Medical Journal; and the 1938–1951 Transactions are to be mimeographed for the Archives. The Transactions have always been printed, but in order to curtail expenses, the back years (1938–1951), which have not been published, are to be brought up to date by the mimeographing method, and the Treasurer's Reports and Membership Rosters for 1948 to 1951, which are in type, are to be printed separately.

As Secretary, and also as Editor of the Journal, Dr. Yeager was empowered to carry out the following recommendations of the Council:

1. *Publication of Faculty transactions in the Journal, and this expense is to be considered under transactions. These were published in the August 1952 Journal.*
2. *In the case where the speaker did not leave the requested copy of the Trimble Lecture, nor was he able to edit the transcription from the tape recording, the Council decided not to publish the transcribed lecture in the Journal as a part of the transactions, but to have it filed in the Archives.*
3. *The membership roster to be published in the Journal.*

One of the duties of the Council under the Constitution and By-Laws is to select the date for the Annual Meeting, and therefore this body selected April 28 and 29, 1953.

As there had been requests for the dates for the 1954 Annual Meeting, the Council has designated April 26, 27, 28, for the 1954 Annual Meeting.

As requested by the Council, Dr. Chesney made inquiry regarding the World Medical Association, and reported his findings to the Council. No action was taken regarding the Faculty becoming a member of this Association.

Several of the hospitals in the City made the request that they be allowed to hold joint staff meetings in the Building and this was approved by the Council with the proviso that the group pay for janitorial service.

Problems, too numerous to include in this report, of policy, membership, procedure, etc. relating to the Component Societies were discussed at each meeting of the Council.

The Council selected members of the Medical and Chirurgical Faculty to serve in designated capacities in the Maryland Medical Service, Inc. and Maryland Hospital Service, Inc., as indicated in the Constitutions and By-Laws of these two organizations.

The Council suggested to the Component Societies that each applicant for membership should be investigated and that the application forms should contain a standard question in which the statement is made that the applicant has, or has not, made application to another Component Society of the Faculty.

The following ruling, in reference to the granting of Physicians' Defense, was received from Mr. G. C. A. Anderson, the Faculty lawyer:

> *The year in which the claim is made should be the decisive year, since it is of the utmost importance that when the defense is undertaken, the physician be a member of the Faculty. If the year in which the claim is made is not the decisive year, it would be possible for an alleged malpractice to occur in one year and the claim be made in another year when the doctor involved might no longer be a member of the Faculty. Under such circumstances, the Faculty would be called upon to defend a non-Faculty member.*

This suggestion is being set forth as an amendment to the Constitution and By-Laws for presentation to the House of Delegates.

Council authorized Physicians' Defense to nine members, who had made such a request. Mr. Anderson reported that one case had been settled out of court.

Mr. G. C. A. Anderson complied with the request of the Council to serve for another year as the legal advisor to the Faculty. Mr. Anderson, however, has raised his retainer's fee fifty per cent. (This is one more of the many reasons why the Council found it necessary to ask for an increase in dues.)

Dr. Chesney met with the State Legislative Council and explained our opposition to the proposed change by the Sobeloff Commission in the appointment of the members of the Board of Medical Examiners.

The present Adoption Law was discussed by Mr. Anderson, and he was asked to write an article for the Journal so that all the members may be informed on this law. (Published in the March 1953 issue of the Journal.)

Legislative matters, which would come before the General Assembly of Maryland at its 1953 meeting, were discussed. Approval of Dr. John Wagner's request for assistance in writing and support of passage of a law relating to postmortem examinations was granted.

The Council, or Executive Committee, advised Dr. Karl Mech and Mr. Kirkman regarding pending legislative bills, which were before the 1953 General Assembly of Maryland and its Committees.

The request by the Committee on Scientific Work and Arrangements, for funds to defray the expenses and honorariums for the Annual Meeting guest speakers, was approved.

The amendments to the Committee on Constitution and By-Laws were discussed at the meeting on February 17th and some of the suggestions were accepted and others were disapproved. Dr. A. A. Pearre, the Chairman of the Committee on Constitution and By-Laws, was present for this discussion, and the report of his Committee will be presented to the House of Delegates meetings on Tuesday and Wednesday, April 28 and 29. The Council urges the House to vote favorably on these amendments, as careful thought has been given to their compilation before this presentation.

Emeritus Members. The Council recommends to the House of Delegates that the following be placed on the list of Emeritus Members:

- Baltimore City Medical Society
  - Dr. Anna S. Abercrombie
  - Dr. Wilbur F. Skillman
  - Dr. Lloyd B. Whitham
- Allegany-Garrett County Medical Society
  - Dr. Francis A. G. Murray
  - Dr. Charlotte B. Gardner
- Charles County Medical Society
  - Dr. Thomas L. Higdon
- Frederick County Medical Society
  - Dr. Charles H. Conley, Sr.
  - Dr. U. G. Bourne, Sr.
  - Dr. William M. Smith
- St. Mary's County Medical Society
  - Dr. Levin J. Sothoron
- Talbot County Medical Society
  - Dr. Edward Kirby Lawson

Respectfully submitted,
C. Reid Edwards, M.D., *Chairman*

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Mr. President and Members of the House of Delegates:

Your delegate attended the sessions of the A.M.A. held in Chicago in June, 1952, and in Denver in December, 1952, as well as the Special Session called for in March of this year.

Dr. Parsons has enumerated in some detail the important things that occurred at these meetings with reference to the special events, in the various numbers of the Journal of the A.M.A. There is no need to repeat this information. However, in December at the Denver Meeting your delegate was requested to attend the Public Relations Meeting in Denver which was a session devoted to Doctor-Patient relationship. This was of only moderate interest to your delegate because the problems that were discussed, namely, excessive professional fees, fee splitting, ghost surgery, abuse of management of the patient and a tendency to quackery, are in your delegate's opinion by no means common practices along the Eastern Seaboard. It is of interest, however, that the meeting was extraordinarily well attended.

At the December session of the House of Delegates your delegate was Chairman of the Reference Committee dealing with the Constitution and By-Laws. This was an interesting experience and the changes made in the Constitution and By-Laws were not fundamental but more editorial changes and changes made for simplification and explanation of the said Constitution and By Laws.

The Special Session called for in March, which was held in the Statler Hotel in Washington, was unique in that a President of the United States addressed the House of Delegates of the A.M.A. President Eisenhower's remarks were of an informal nature and though he states that he does not like the words "Compulsory" and "Socialized," part of his program certainly indicated that the above is being done though not without specific terms. The reorganization of the Federal Security Agency is now an accomplished fact and it is your delegate's opinion that the move suggested by the Board of Trustees of the A.M.A. for approval of this change was a step in the right direction. At least the American Medical Profession is now on the "inside" and is in a better position to exert its influence in the right direction. The set up in the new department places the Medical Profession in a distinct and separate group directly under the Secretary for that Department.

Your delegate has enjoyed more than usual his experience at the last three sessions of the House of Delegates of the A.M.A. that he attended as your representative.

Respectfully submitted,
Warde B. Allan, M.D.

Mr. President and Members of the House of Delegates:

As your Delegate to the House of Delegates of the American Medical Association, I attended the meetings of that House in Chicago June 9 to 13, 1952, in Denver, Colorado December 2nd to 5th, 1952, and the Special Meeting of the House in Washington on March 14, 1953. The proceedings of the two regular meetings are reported in the Journal AMA on July 5, 1952 and December 22nd, 1952. It is felt inappropriate to attempt a complete summary of these proceedings in this report. All those matters which our Delegates have been instructed to present to the House were found to have been introduced for consideration by other Delegates and all were reported for favorable consideration.

A large portion of the activities of the governing body of the American Medical Association in recent years has had to do with the fight against attempts to socialize medicine. It appears that the change of administration in Washington will result in at least a breathing spell in those efforts. At the June meeting in Chicago there was a long debate over the President's commission to study the health needs of the Nation which was finally resolved into a wait-and-see attitude. Since the publication of the report of that Commission, dealing with recommendations, the President of the American Medical Association, Dr. Louis H. Bauer, has reported that the Board of Trustees and the American Medical Association will continue a watchful eye over any legislation proposed to implement those recommendations of the Board which may bring about further encroachment by the Federal Government in the realm of medical care.

At the meeting in Washington on March 14, President Eisenhower and Senator Taft described the proposed re-organization of the Federal Security Administration into a Department of Health Education and Welfare to be headed by a Cabinet member. It is anticipated that by the time this report is read to the House of Delegates, that re-organization will have been accomplished. The Board of Trustees of the American Medical Association recommended "that the House of Delegates re-affirm its stand of an independent Department of Health but that it support the re-organization plan as being a step in the right direction, and that the American Medical Association co-operate in making the plan successful and watch its development with great care and interest. It should be understood, however, that the Association reserves the right to make recommendations for amendment of the then existing law and to continue to press for the establishment of an independent Department of Health, if the present plan does not, after a sufficient length of time for development, result in proper advancement in, and protection of health and medical science and in their freedom from political control."

Another matter which has received considerable attention in the House of Delegates of the Medical and Chirurgical Faculty, tax exemption for retirement benefit plans, has been under careful consideration by the American Medical Association in conjunction with the American Bar Association and other organizations having a similar interest. The Reed-Keough Bill, now in Congress, has many supporters and it is anticipated that favorable legislation in this direction may be anticipated.

Respectfully submitted,
John W. Parsons, M.D.

BOARD OF MEDICAL EXAMINERS

Mr. President and Members of the House of Delegates:

The Board of Medical Examiners is composed of the following members:

Dr. E. H. Kloman	(1955)	President
Dr. Henry T. Collenberg	(1953)	Vice President
Dr. Lewis P. Gundry	(1954)	Secretary
Dr. E. Paul Knotts	(1953)	
Dr. John E. Legge	(1956)	
Dr. Edward P. Thomas	(1954)	
Dr. John H. Hornbaker	(1955)	
Dr. Samuel McLanahan*	(1953)	

The terms of Dr. Collenberg and Dr. Knotts expire on the first Tuesday in June, 1953, therefore two members to serve until June 1957, and one member to fill the vacancy caused by the death of Dr. Hanrahan, to serve until June 1956, are to be elected at this meeting of the Faculty.

Examinations given by this Board during the year show the following results:

Examined for license	228
Number passed	213
Number failed	15

---

* Dr. McLanahan has been serving the term of Dr. E. M. Hanrahan who had been on leave of absence on account of illness but died on September 30, 1952.

Of the 15 who failed, 13 were graduates of foreign medical schools, one was a graduate of Meharry Medical College, the other a graduate of the University of Chicago.

Licenses issed after examination	213
Licenses issued by reciprocity with other States	85
Licenses issued in recognition of National Board certificates	70
	—
Total licenses issued	368
Certificates of transfer to other States	230
Borderline Permits to District of Columbia licentiates	40
Copies of license issued	4
Miscellaneous—change of name etc	5
Foreign graduates approved for examination	54
Written inquiries from foreign graduates	234
Office interview with foreign graduates (approx.)	150
Telephoned inquiries—no record	
Foreign graduates examined	39
Passed—foreign	26
Failed—foreign	13
Licenses revoked	2
Licenses restored	2

One of the physicians, whose license was revoked, appealed from the decision of the Board but the case was not set for hearing until a few days ago although the appeal has been pending more than a year. The doctor concerned has, of course, been practicing during the interval. The Hearing set for March 26 was postponed by the Assistant Attorney General on account of serious illness of his father.

In June 1950 this Board reported to the State's Attorney of Montgomery County that one David Aitchison, Takoma Park, Maryland, not licensed to practice medicine in Maryland, but listed in the Washington telephone directory as a naturopath, was apparently using the mails to practice medicine, and, since he calls his address the Aitchison Clinic, is probably practicing medicine in Maryland without a license. Naturopathy has not been recognized as a branch of Healing in Maryland, and in a recent case it was held in the Criminal Court of Baltimore City that the practice of naturopathy is a violation of the Medical Practice Act. We sent the State's Attorney a copy of a letter sent by Aitchison to a patient in New Jersey, in which he said in part "as I specialize in cancer." After much correspondence with Mr. Dawson, and with the Montgomery County Medical Society, we were informed on October 9, 1951 that he was "unable to find any evidence that he was actually practicing medicine." Photostat copy of the letter sent by Aitchison to New Jersey was sent to the Post Office Inspector at Washington, D. C., but on April 25, 1952 we were informed that the investigation had brought out no evidence warranting action for violating Postal Fraud Statutes.

During the 1953 session of the General Assembly of Maryland the Naturopathic Society of Maryland introduced a Bill to establish a Board for licensing Naturopaths. In this connection Aitchison wrote a letter to one of the delegates stating that the passage of this Bill would be worth $20,000. Testifying before a Senate Committee, Aitchison made the statement that he had about 1% mortality in his practice as against 22% for the medical doctors. The Bill was not reported out of Committee.

On two occasions Mr. Boyd Martin discussed with the members of the Board the problem of physicians who are drug addicts and the efforts of the Narcotic Bureau to rehabilitate such persons.

The Board of Medical Examiners feels that the Naturopaths, some of whom are very probably practicing medicine, should be vigorously prosecuted wherever they are located. The Board would like to have the full backing and support of the Medical and Chirurgical Faculty in this matter.

The Board has supplemented their policy on graduates of foreign medical schools in that we are considering on an individual basis graduates of foreign schools which have not been surveyed or rated but who have had exceptional post-graduate training.

Respectfully submitted,
Lewis P. Gundry, M.D., *Secretary*

N. B. in re

STATE PRACTICE ACT

State Board of Medical Examiners—Henry T. Collenberg, Lewis P. Gundry, John H. Hornbaker, John E. Legge, Samuel McLanahan, Norman E. Sartorius, Jr., Edward P. Thomas, Erasmus H. Kloman, Secretary, 1215 Cathedral Street, Baltimore 1, Maryland

Meetings of the Board of Medical Examiners of Maryland—The regular annual meeting is held the first Tuesday in June and other meetings are held about four times a year at such times as the discretion of the Board may determine. Special meetings are held from time to time to consider particular policies or problems.

Regular Examinations—Examinations are held in Baltimore, the third Tuesday in June for four consecutive days and the second Tuesday in December for four consecutive days.

Reciprocity or Endorsement Information—The license of the Board of Medical Examiners of Maryland is recognized for license without examination in the following States: Alabama, Arkansas, California, Connecticut, Delaware, District of Columbia, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wisconsin.

Diplomates of the National Board of Medical Examiners are also admitted to license without examination.

Information connected with Medical Examinations and licensure by addressing the Secretary, 1215 Cathedral Street, Baltimore 1, Maryland.

LIBRARY COMMITTEE AND FINNEY FUND COMMITTEE

Mr. President and Members of the House of Delegates:

This report covers the activities of the Library and Finney Fund Committees.

Several changes in personnel took place in the Library about November 1st, 1952, when Miss Pauline Duffield left here to become librarian of the Texas Medical Society Library in Austin, Texas. About the same time Miss Freda Hewes, a full-time assistant, and Mrs. Bettie McQuay, a half-time assistant accepted better paying positions.

On November 1st Miss Helen Wheeler took up her duties here as Librarian with only Mrs. Eleanor Kohler as assistant, and Mrs. Ella Chatt as janitress and assistant in the stacks. The Library Committee and the Council agreed to Miss Duffield's and Miss Wheeler's recommendation that the salaries of the two assistants who had left be combined to employ a trained cataloger, and on December 15th Mrs. Henry Berge joined the staff as assistant librarian and cataloger. Her previous training and experience have made her exceptionally well qualified for the work here.

Miss Duffield had accomplished a tremendous job in getting an accumulation of material, including several large gift collections, cataloged and organized. She also had a complete record made of the periodical holdings (a truly tremendous task) and sorted and arranged the large collection of duplicates in the basement.

The following are the recommendations of Miss Wheeler, (1) more shelf space, (2) additional library equipment such as filing cabinets, card catalog units, another book truck, etc., (3) recataloging and reclassifying of the book collection, (4) an additional clerical assistant to help with this project.

(1) There is absolutely no room for more shelving in the stacks. The librarian therefore recommends placing double faced shelving in the Reading Room at right angles to the walls between the windows, forming alcoves where the small study tables may be placed. This will make it possible to keep many more books in the Reading Room where they are easily accessible, and will make the room look more like a library.

(2) The present filing cabinets, etc., are bursting at the seams, and more equipment is essential for efficient operation. Some have already been ordered.

(3) Recataloging and reclassification of the book collection are necessary because the system in use is one which was devised by Miss Noyes in the days when the library was small. This system is out of date and is used by no other library. Also the subject headings are inconsistent and difficult to use.

After much deliberation the staff have decided that the Library of Congress classification would be the best for our purpose. It is revised frequently, and a new edition of the classification for Medicine has just been published. This is the system in use in both the Welch Medical Library and the University of Maryland Medical Library and would be familiar to the doctors using the library.

(4) This project involves much clerical work such as typing and filing cards which could be done by a clerical assistant under Mrs. Berge's direction. One additional assistant is a very modest request in view of the magnitude of the task of changing thousands of cards as well as books. When completed this reorganization will greatly facilitate the use of the Library and will permit opening the stacks to readers. Mrs. Berge has started the reclassification single-handed, but without additional help it will take years. Five hundred and twenty-one volumes have been classified or reclassified in the first 3 months of 1953, and there are between 30,000 and 40,000 still to be done!

When the new stacks are installed in the Reading Room, some of the glass-doored bookcases may be used to protect and display our rare books, which are now very inadequately housed in the stacks.

Back files of the Bulletin of the Medical Library Association have just been removed by the Association early this month (April 1953), relieving the library staff of much time-consuming work, and releasing a large section of shelving in the basement stacks for expansion of our crowded periodical collection.

The Library has been represented in each issue of the Maryland State Medical Journal by an article or a book list. In a new series of articles beginning with the May 1953 number, Dr. Krause is calling attention to some of the fine old books in our collection. The first of these articles includes a list of our books both old and new on "Old Age." Suggestions for other types of articles for the Library section of the Journal will be most welcome.

The reference and information service given by the Library is extensive and takes a great deal of time. Two hundred and forty-two requests for information have been recorded in the first quarter of 1953, varying from furnishing a doctor's name or address to compiling or checking extensive bibliographies, and probably an equal number were filled without being recorded in our statistics.

In addition to the regular work, an index to the Maryland State Medical Journal for 1952 has been compiled, and also a very useful subject index to the periodicals currently received by the Library.

A book-buying policy for current material in cooperation with other medical libraries in the city is under consideration.

A survey of the periodicals currently received is planned with recommendations for new subscriptions, and suggestions from users of the Library will be welcome.

The possibility of effecting a considerable saving in the cost of our periodicals by placing all our paid subscriptions through an agent is being investigated. This will also simplify payments.

A consolidation of periodical records is also envisioned, combining the 5 sets of records now in use into one or two.

The air-conditioning of the Reading Room and office has been brought to your attention before, and this should be done, as it will increase the use of the Library in summer, besides adding to the comfort and efficiency of the staff.

Miss Wheeler states that she cannot speak too highly of the splendid cooperation of the members of the library staff and of their enthusiasm for the proposed changes. My grateful thanks go to Miss Wheeler, Mrs. Berge, Mrs. Kohler and Mrs. Chatt for their fine spirit and work. Having two new staff members come about the same time could have been very difficult without the wholehearted assistance of Eleanor Kohler and Ella Chatt.

A Statistical report is appended.

Respectfully submitted,
LOUIS KRAUSE, M.D., *Chairman*
Library Committee
SAMUEL WOLMAN, M.D.
JOHN T. KING, M.D.
A. AUSTIN PEARRE, M.D.
WILLIAM K. DIEHL, M.D.
JOSEPH C. BIDDIX, JR., D.D.S.
Finney Fund Committee
DOUGLAS H. STONE, M.D.
HENRY M. THOMAS, M.D.
JOHN M. T. FINNEY, JR., M.D.
LOUIS P. HAMBURGER, M.D.
I. RIDGEWAY TRIMBLE, M.D.

LIBRARY REPORT

1952

CIRCULATION AND ATTENDANCE	
Circulated books	5,919
Books used in Library	3,326
Total	9,245
Total volumes in 1951	75,562
Books added, 1952	299
Journals added, 1952	433
Total volumes in Library (including 15,000 duplicates)	76,294
Attendance	4,137
MEDICAL LIBRARY ASSOCIATION	
Issues sent on exchange	360
CARDS ADDED TO THE CATALOG	
Library of Congress cards	1,172
Typed cards	316
Shelf list cards	636
Added information	290
Collection cards	199
Total	2,613
BINDING	
Journals bound	433
Total cost	$1373.85
Average cost per journal	$3.08
COUNTY MEMBERS	
Requests for material	41
GIFTS	
Unbound journals	12,962
Bound journals	344
Books	2,052
Reports and transactions	263
Reprints	7,267
Pictures	3
Total	22,891
PETTY CASH REPORT	
Received from office and refunds on express and postage	$280.48
Expenses	275.48
Balance on hand December 31, 1952	$5.00
INTERLIBRARY LOANS	
Loaned	
Air Research Library	1
All American Airline	1
Baltimore City Health Department	3
B. & O. Railroad	1
Chemical Company	1
Easton Memorial Hospital	3
Enoch Pratt Free Library	14
Florida State University	1
Fort Howard Hospital Library	51
Franklin Square Hospital	2
Harford Memorial Hospital	1
Hynson, Westcott, and Dunning	22
Johns Hopkins University	2
Maryland General Hospital	9
Maryland Tuberculosis Assn.	1
Medical College of S. Carolina	1
Medical College of Virginia	1
National Laboratory	1
Ohio State University	2
St. Agnes Hospital	9
St. Joseph's Hospital	13
Seton Institute	3
Sheppard Pratt Hospital	19
Sinai Hospital	28
Social Security Library	1
U. S. Naval Medical School	1
U. S. Public Health Hospital	1,173
University of Maryland	8
Welch Medical Library	82
Wilmer Institute	3
West Virginia University	1
Total	1,459
Borrowed	
U. S. Public Health Hospital	7
University of Maryland	9
Welch Medical Library	22
Total	38

LIBRARY OF THE MEDICAL AND CHIRURGICAL FACULTY

GIFTS FOR 1952

NAME	REPRINTS	REPORTS	BOUND JOURNALS	JOURNALS	BOOKS
Abeshouse, Dr. Benjamin S.	5				
Acton, Dr. Conrad				209	23
Albany Medical College, Albany				1	
American Cancer Society		1			2
American Medical Association					4
Andrus, Dr. E. Cowles					1
Armco Steel Corporation				51	
Armed Forces Medical Library				92	
Army Medical Service Graduate School					1
Association of American Physicians		1			
Bagley, Dr. Charles, Jr.				39	
Baker, Dr. Joel W.	2				
Baltimore City Dept. of Public Welfare		1			
Baltimore Commissioner of Health		1			1
Barta, Dr. Frank R.	1				
Beck, Mrs. Harvey G.	376		40	300	592
Boston Medical Library				82	
Boston Psychopathic Hospital Library				2	
Brady, Dr. Leo				48	
Brantigan, Dr. Otto C.	6			110	
Carson, Dr. Russell B.					1
Chatard, Dr. J. Albert (1 Picture)				103	14
Chicago, Department of Health		1			
Christ Hospital Institute of Med. Res.				1	
Church Home Hospital		1			
Cincinnati General Hospital Medical Lib.				2	
Coggins, Dr. J. C.				100	
Cole, Dr. J. Wesley				241	468
College of Medical Evangelists, Los Angeles					24
College of Physicians, Philadelphia		1			1
Cotton, Mrs. Albertus			35	354	
Cullen, Dr. Thomas S.				118	
Cushing, Dr. Mary				80	
Dandy, Mrs. Walter E.	3850				
Delaware Academy of Medicine Library				2	
Duke University, Durham					1
Dunton, Dr. William R.	300			24	
Edwards, Dr. Monte				97	
Emory University				2	
Federal Security Agency, Washington					1

LIBRARY GIFTS—*Continued*

NAME	REPRINTS	REPORTS	BOUND JOURNALS	JOURNALS	BOOKS
Feldman, Dr. Maurice, Sr.				117	
Fleischmann, Dr. Walter	400		10	225	
Fort, Dr. Wetherbee (2 pictures)					34
Friedenwald, Dr. Jonas S.				203	
Garlick, Dr. William					1
Geraghty, Dr. Frank J.				91	
Gillis, Dr. Andrew C.				2	
Gluck, Dr. Francis W.				735	
Goldbach, Dr. L. J.				547	
Goldstein, Dr. Albert E.	9				
Goodman, Dr. Louis E.				2	
Gundry, Dr. Alfred T.				395	
Harvard University, Boston					3
Health Information Foundation					1
Heckel, Dr. N. J.		1			
Hellman, Dr. Alfred M.					1
Hennepin County Medical Library, Minn.				12	
Henry Ford Hospital, Detroit				3	
Henry Phipps Institute, Philadelphia		1			
Heyden Chemical Corporation	1				
Hoak, Dr. W. H.			4	3	
Howard, Dr. J. T.				69	
Hundley, Dr. J. M., Jr.				161	
Hunner, Dr. Guy L.					1
Hyman, Dr. Calvin				2	
Hynson, Westcott and Dunning				64	1
Indiana University, Indianapolis				12	
Institute for Cancer Research				1	
Institute for the Study of Analgesic and Sedative Drugs					1
Iowa State Medical Library, Des Moines				6	
Janney, Dr. John H.				30	
Jefferson County Medical Library, Louisville				1	
Karnes, Dr. James R.				15	
Kirby, Dr. F. J.				398	
Kirkman, Walter M.				1	1
Knox, Dr. J. H. Mason, III	2497	235	194	688	242
Koontz, Dr. Amos R.			34	185	71
Krause, Dr. Louis A. M.	18		32	150	36
Krumrein, Dr. L. F.				605	1
Kyoto University Library, Kyoto, Japan					1
Lang, Dr. Milton C.				16	2
Lane Medical Library				3	
Lederle Laboratories					2
Lerner, Dr. P. F.				56	

LIBRARY GIFTS—*Continued*

NAME	REPRINTS	REPORTS	BOUND JOURNALS	JOURNALS	BOOKS
Lewison, Dr. Edward				96	
Life Insurance Medical Research Fund		1			
Lilly Research Laboratories Library				17	
Lippincott, J. B. Company		1			
Louisiana State University				10	
M. R. Laboratories, Columbus		3			
Marriott, Dr. H. J. L.					1
Maryland State Department of Health				195	100
Maryland General Hospital				141	
Maryland Tuberculosis Association				236	
Massachusetts General Hospital, Boston		1			
Maxson, Dr. Charles W.	13			212	
Mayo Clinic Library				91	
McGavack, Dr. Thomas H.	5				
McKenzie, Dr. W. Raymond	4				
Medical Society of Pennsylvania				18	
Menninger Clinic, Topeka				10	
Merck and Company				1	3
Moore, Dr. J. E.		1		731	43
Morrison, Dr. Samuel				3	
Moulton, Dr. George A.	7				
Myers, Dr. John A.				56	
National Dairy Council	4				
National Foundation for Infantile Paralysis		1			4
Naval Medical Research Institute Library				2	
New York Academy of Medicine				175	
New York Pathological Society		1			
Northwestern University Medical School				26	1
Novak, Dr. Emil					2
Nowak, Dr. Sigmund				109	76
Ortho Research Foundation				8	
Padget, Mrs. Paul				6	1
Pan American Sanitary Bureau, Washington				2	
Parke, Davis and Company				8	
Pfizer, Charles, and Company					1
Penick, S. B. and Company					1
Pratt, Enoch, Free Library		1			
Rockefeller Foundation	24	2			
Rockefeller Institute for Medical Research				123	2

LIBRARY GIFTS—*Continued*

NAME	REPRINTS	REPORTS	BOUND JOURNALS	JOURNALS	BOOKS
St. Anne's Hospital Medical Library, Chicago				2	
St. Francis Sanatorium for Cardiac Children, Roslyn, N. Y.		1			
St. Joseph's Hospital				16	
Shamer, Dr. M. E.				39	
Shealy, Dr. Walter H.				93	
Sheppard Pratt Hospital				30	
Shipley, Dr. A. M.				158	
Small, Dr. Mary L.				40	
Societa Italiana de Ortopedia e Traumatologia		3			
Southwestern Medical School Library				1	
Stone, Dr. Harvey B.		2			
Temple University Medical School Library				7	
Tenner, Dr. David				29	1
Thorex, Dr. Philip	1				
Union Memorial Hospital				115	
U. S. Public Health Hospital				19	
University of California				4	
University of Illinois				95	
University Laval Bibliotheque Medicale				4	
University of Maryland				4	1
University of Southern California				1	
University of Texas				1	
University of Toronto				10	
University of Wisconsin				22	
Upjohn Company Library				3	
Vanderbilt University				8	
Wainwright, Dr. Charles				46	
Walton, Dr. Harry J.				343	
Ward, Dr. Grant E.				118	
Wells, Dr. Gibson J.				312	
Werner, Dr. A. A.					1
Wesson, Dr. Miley B.	14				
Wharton, Dr. L. R.				54	
Williams & Wilkins, Waverly Press				22	12
Wilmer Institute of Ophthalmology			(collected repr.)		1
Wiscott, Mr. W. J.				1038	
Wise, Dr. Walter D.			21	64	
Woltereck, Dr. G. H.				101	
Yale Medical Library, New Haven		1			

COMMITTEE ON SCIENTIFIC WORK AND ARRANGEMENTS

Mr. President and Members of the House of Delegates:

The Semiannual Meeting, held in Ocean City on September 12, 1952, will go down in the Archives as a very well attended meeting which everyone enjoyed. (Program follows this report.) Many of the doctors brought their families and made it a weekend vacation for the end of the season. This is the second consecutive year that the Semiannual Meeting has been held in Ocean City. I would like to express, on behalf of the Faculty and the Committee on Scientific Work and Arrangements, our appreciation to the local Committee consisting of Dr. Francis J. Townsend, Jr., Dr. Osborne D. Christensen, Dr. Norman E. Sartorius, Jr., and Dr. Thomas B. Whaley. Without the assistance of this group the Meeting would not have been so worthwhile from a scientific standpoint or so enjoyable from the social angle. Attached is a copy of the program.

This year the Annual Meeting is being held at the usual time, the fourth Tuesday and Wednesday in April. (See pages 109 to 114, Maryland State Medical Journal, Vol. 2, No. 3, March 1953.) With the growth and increase of the many medical associations, it may become impossible in the future to avoid conflict with other groups. However, the Constitution and By-Laws have made an effort to provide for this and the Council sets the date of the Meeting for the future. It is too early to report on the success of the 1953 Annual Meeting. The Annual Meeting for 1954 will be held on Tuesday and Wednesday, April 27 and 28.

At the request of the President, Dr. Maurice C. Pincoffs, we have provided outstanding speakers for all the scientific sessions. The usual procedure has been followed for the evening meetings with the Presidential Address and a special lectureship on Tuesday and a more elastic program for Wednesday evening following the buffet supper. However, the meetings during the day have been arranged so that there is a paper every twenty minutes, and it is hoped that, regardless of what the specialty or interest of the individual member may be, he will find something of value in this program. The complete program was published in the March issue of the Maryland State Medical Journal, and individual programs were mailed to all members. (See pages 109 to 114, Maryland State Medical Journal, Vol. 2, No. 3, March 1953.)

The Committee on Scientific Work and Arrangements would appreciate knowing whether or not the members of the Medical and Chirurgical Faculty like this small program, which measures 4′ x 7′ or whether they prefer the one which is a little larger, measuring 5¼′ x 7½′. The Committee always welcomes suggestions, criticisms, etc. of the programs.

Looking to the future, the 1953 Semiannual Meeting is being held on October 6, 1953 at the Congressional Country Club in Bradley Hills. This will be the fiftieth anniversary of the Montgomery County Medical Society, and it is hoped that every member will make reservations well in advance and plan to attend this Meeting.

Respectfully submitted,
Beverley C. Compton, M.D., *Chairman*
William L. Garlick, M.D.
Edwin H. Stewart, Jr., M.D.

PROGRAM OF THE SEMIANNUAL MEETING

Headquarters: Commander Hotel, The Boardwalk and 14th Streets, Ocean City, Worcester County, Maryland.

Friday, September 12, 1952

Registration—9:00 A.M. Lobby, Ocean Entrance. (All the members and their guests are urged to register so that an accurate record may be kept of the attendance.) Those who arrive on September 11th may register on Thursday, September 11th from 7:30 P.M. to 9:30 P.M.

Business Sessions:
Council Meeting—Thursday, September 11th, 8:30 P.M. Beach Lounge, Ground Floor
House of Delegates—Friday, September 12th, 9:30 A.M. to 12 noon. Beach Lounge, Ground Floor

Clam Bake-Luncheon—1:00 P.M.
On the beach in front of Commander Hotel. Set-ups and hors d'oeuvres

General Meeting—2:30 P.M.: Beach Lounge, Ground Floor

1. Address of Welcome. I. Rivers Hanson, M.D., President, Wicomico County Medical Society.
2. Response. Alan M. Chesney, M.D., President, Medical and Chirurgical Faculty of the State of Maryland.

Scientific Session

3. Geriatrics in General Practice. (I. Ridgeway Trimble Fund Lectureship.) Wingate M. Johnson, M.D., Professor of Clinical Medicine and Director of the Private Diagnostic Clinic, Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, North Carolina.

Cruise on "The Question Mark"—2:30 P.M. to 4:00 P.M.: Meet in the Social Room, Main Floor, and the hostesses will make the necessary arrangements for the cruise.

Miniature Golf Tournament—2:30 P.M. to 4:00 P.M.: (Prizes) Meet at the Golf Course, Baltimore and Somerset Streets. Guests of the Somerset, Wicomico and Worcester Counties Medical Societies.

"Breather"—5:00 P.M. to 7:00 P.M.: See copy of "The Visitor," obtainable at all hotels, for general listing of Ocean City Attractions.

THE ATLANTIC OCEAN IS AVAILABLE AT ALL TIMES

Dance—9:00 to 1:00 A.M.: Dining Room, Main Floor. Dress—Formal or Informal. Hosts—The Somerset, Wicomico, and Worcester Counties Medical Societies.

PLEASE BE SURE TO MARK YOUR RESERVATION CARD, WHICH IS ENCLOSED, FOR YOURSELF AND NUMBER OF GUESTS SO OUR HOSTS MAY BE NOTIFIED OF THE ACCEPTANCES

WOMAN'S AUXILIARY TO THE MEDICAL AND CHIRURGICAL FACULTY

10:30 A.M. to 12 Noon
Social Room, Main Floor

Winning Ways with Patients. Mr. Leo E. Brown, Director, Department of Public Relations and Assistant to the General Manager, American Medical Association, Chicago, Illinois.
A cordial invitation is extended to all the ladies to attend this meeting.

COMMITTEES

Arrangements Committee: Dr. Francis J. Townsend, Jr., *Chairman*, Worcester County; Dr. Osborne D. Christensen, Wicomico County; Dr. Norman E. Sartorius, Jr., Worcester County; Dr. Thomas B. Whaley, Somerset County.

Reception Committee: Dr. William H. Fisher, Jr., *Chairman*, Wicomico County; Dr. Charles T. Fisher, Wicomico County; Dr. Seth H. Hurdle, Wicomico County; Dr. Louis G. Llewelyn, Worcester County; Dr. Norman E. Sartorius, Jr., Worcester County; Nathaniel R. Thomas, Worcester County; Dr. T. B. Whaley, Somerset County.

Hostess Reception Committee (Woman's Auxiliary): Mrs. Osborne D. Christensen, Wicomico County, and Mrs. William B. Long, Wicomico County, *Cochairmen;* Mrs. Henry A. Briele, Wicomico County; Mrs. John M. Bloxom, Wicomico County; Mrs. Seth H. Hurdle, Wicomico County; Mrs. Philip A. Insley, Wicomico County; Mrs. Frank R. Lewis, Wicomico County; Mrs. Hunter R. Mann, Jr., Wicomico County; Mrs. Norman E. Sartorius, Jr., Worcester County.

Fishing and Cruising Committee: Dr. Henry A. Briele, *Chairman*, Wicomico County; Dr. William B. Long, Wicomico County; Dr. Norman E. Sartorius, Jr., Worcester County; Dr. Zack Waters, Wicomico County; Dr. Thomas B. Whaley, Somerset County.

NOTES

Hotel Reservations: It is suggested that if you have not made your reservations that you do so immediately by writing to Mr. John B. Lynch, Proprietor, Commander Hotel, Ocean City, Maryland. All reservations for rooms are to be taken care of by members writing *direct* to the hotel.

Rates at the above hotels, which include meals and ocean bathing facilities, are as follows:

$12.50 per person per day for ocean front, private or connecting bath.
$11.50 per person per day for ocean or bay view, private or connecting bath.
$9 50 per person per day for room with running water.

The following hotels are the ones cooperating with the Commander Hotel and if you are staying at one of these there will be a credit of $2.00 on your hotel bill for cover charge for the *clam bake:*

Commander Hotel—Headquarters
Atlantic Hotel
George Washington Hotel
Royalton Hotel.

Clam Bake-Luncheon: This will also include lobsters, fried chicken, steamed crabs, crab fingers, steamed shrimp, deviled crabs, potatoes, corn on the cob, cheese, pickles and crackers. Hors d'oeuvres and set-ups will be served, but there are no provisions made at the Commander Hotel for the licensed sale of alcoholic beverages. *Cover charge*, including tip, is $3.00 per person. Checks should be made payable to the Medical and Chirurgical Faculty and should be mailed to 1211 Cathedral Street not later than FRIDAY, SEPTEMBER 5, 1952, sooner if possible. Upon receipt of check, tickets will be mailed promptly. If you are staying, on the American Plan, at one of the four cooperating hotels, upon presentation of the ticket stub, you should receive a $2.00 credit on your hotel bill.

Cruise: This feature has been arranged by the Medical and Chirurgical Faculty and tickets will be mailed for those for whom reservation is made. It is necessary to know the number of guests who plan to go on the cruise, so please indicate the names of those going on your reservation card, which is enclosed.

Miniature Golf Tournament: Make reservations on enclosed card. Indicate by name who is playing so tickets may be mailed. This has been arranged by the host societies for those ladies who do not wish to go on the cruise. Keep your score, there will be prizes.

Dance: This is an attractive climax to the Semiannual Meeting and the members are urged to remain for the occasion. There are no provisions made at the Commander Hotel for the licensed sale of alcoholic beverages. So that the host Societies may have the number of guests who will attend, please mark your reservation card, which is enclosed.

Parking Facilities: Ample parking space in close proximity to the Commander Hotel.

Fishing: Boats available for fishing. See enclosure with this program.

PROFESSIONAL CONDUCT COMMITTEE

Mr. President and Members of the House of Delegates:

During the past year thirty-three (33) complaints have been received by the Professional Conduct Committee. In each instance the doctor or doctors involved have been contacted, the Committee has studied the case and the complaint answered.

One meeting of the entire Committee was held in September and cases through that date were discussed. Complaints received from September to April were handled with the Committee by the Secretary, who is an ex officio member, through telephone calls, correspondence and informal meetings.

Respectfully submitted,
Charles W. Maxson, M.D., *Chairman*
George H. Yeager, M.D., *Secretary*
Alan M. Chesney, M.D.
Walter D. Wise, M.D.
A. Austin Pearre, M.D.
W. Houston Toulson, M.D.
C. Reid Edwards, M.D.
Maurice C. Pincoffs, M.D.
J. Albert Chatard, M.D.

EDITOR, MARYLAND STATE MEDICAL JOURNAL

Mr. President and Members of the House of Delegates:

On March 31st, 1953, a Journal Representative luncheon was held in the Faculty Building to which those members who have been selected by the Component Society to supply material pertinent to their locality, and the Editorial Board, were invited.

This was well attended and the concensus of opinion seemed to be that this should be an annual procedure. Those attending were Doctors Conrad Acton, J. Tyler Baker, L. M. Cuvillier, Jesse S. Fifer, W. H. Foard, Hugh J. Jewett, G. William Martin, Emil Novak, Theodore Shrop, Donald L. Somerville, O. D. Sprecher, Jr., John A. Wagner, John M. Warren, and Mr. Kirkman.

Mrs. Katherine Tyson, Assistant Publicity Manager of WBAL and WBAL-TV, talked informally relative to obtaining views and effective interesting writing. Her talk evoked considerable discussion. Other topics discussed were Journal expense, the use of symbols for the various journal departments, the monthly news items, the use of photographs, etc.

During the past year the Council has submitted suggestions or recommendations regarding publications in the Journal to the Editor and some of these as a matter of permanent record are included in this report.

The Council approved of accepting a modified form of advertisement for alcoholic beverages in the Journal.

The Council instructed the Editor to publish the Transactions of the Medical and Chirurgical Faculty in the Maryland State Medical Journal. The Transactions of the 1952 Annual Meeting were published in the August Journal for that year. The Council also ruled that the Membership Rosters of the Association are to be printed in the Journal, as these are a part of the Transactions. For 1952, these appeared in the December issue, however, for 1954 it is planned to have the list in either the May or June Journal.

It was brought to the attention of the Council by Dr. George H. Yeager as Secretary of the Faculty and Editor of the Journal, that one of the Trimble lecturers did not leave a written copy of his address. This was requested several times prior to Annual Meeting. These lectures are an integral part of the Archives of the Faculty and the Transactions. The stenotypist made a copy of this lecture which has been sent to the speaker for editing, but it has been impossible to obtain an edited copy. The concensus of opinion of the Editorial Board of the Journal was that this paper should not be published without approval and editing by the author. The suggested ruling of the Editorial Board was confirmed by Council, and in this specific case the transcript is to be filed, but this Trimble Lecture will not be published as a part of the Transactions of the Faculty.

The Maryland State Medical Journal has now been published for one year. Its reception by the membership would seem to justify its continuation.

Mr. Kirkman will include a financial report elsewhere.

Eventually definite office space should be assigned to the Editor, in order to improve general efficiency in compilation of Journal material.

Respectfully submitted,
George H. Yeager, M.D., *Editor*

CURATOR

Mr. President and Members of the House of Delegates:

This is the first formal report I have made since the new office of "Curator of the Faculty" was designated by your Council.

To our many members who *never* or *rarely* come to the "Faculty Building" this appointment may seem unnecessary and why should it be necessary to supervise the "things" housed there. To the few members who come often, and know what is contained in the four walls of your building, this desire on the part of your Council is greatly appreciated.

Personally, my being designated as "curator" means very little, as any member with a little time and interest would handle the supervision better, but the main point I wish to bring out is that now, the Council wishes to bring to the attention of our "invisible members" the importance and value of the "things" which may have meant so little to them.

Much has been gathered over years, by your members urging friends or patients to leave to us for safekeeping in our rooms, portraits, diplomas, valuable manuscripts, old instruments and curios. I wonder just how often these are seen by our members. They are there to look at, admire, and help us to cherish past glories with the present and as an aid and impetus to collecting more in the future.

We sometimes travel far and go to much trouble to wander through old museums and galleries which illustrate the glories of the past. Certainly, our more than 150 years of medical progress has been well illustrated by our portraits, books and museum pieces. Have we given enough praise to some of our former members? Many names could be considered, but there are too many to mention in this report. One, I must, and that is John Ruhräh, who did so much for us during his life and left us a very wonderful financial inheritance.

Bringing this report up-to-date, I would like to mention that during the past year we have been given a portrait of Dr. Nathaniel G. Keirle, as well as mementoes which belonged to other members. The Small Hall is now the business office of the Medical and Chirurgical Faculty and the Baltimore City Medical Society. This was necessitated due to the expansion of work. The portraits and busts which were in the Small Hall have been moved to the room on the lower floor formerly known as the Supper Room. The Sections of the Baltimore City Medical Society and other groups hold their meetings here, but this room will accommodate about one hundred. The Upton Scott Chest and the Napoleon Case are now being housed temporarily on the third floor in the Finney Howell Research Room. These changes are all for the better, I think.

Do come now and see what has been accomplished.

Respectfully submitted,
J. Albert Chatard, M.D., *Curator*

MEDICAL ADVISORY COMMITTEE TO SELECTIVE SERVICE

Mr. President and Members of the House of Delegates:

Before presenting to you the most recent figures on the number of doctors eligible for military service in this state and their present status, I would like to restate again the conditions for eligibility for military service under the Doctor Draft Act.

(1) Those doctors who received any part of their medical education at government expense during World War II, or who were deferred from the draft at that time in order to complete a course of study and who have not had more than 89 days of military service since receiving their degree in medicine, are classified Priority I.

(2) Those doctors who have had more than 89 days of military service since receiving their degree in medicine but who have had less than 21 months of military duty are classified Priority II.

(3) Those doctors who have had no military service since September 16, 1940 and who are under 51 years of age are classified Priority III.

(4) Those doctors who are veterans of World War II, even though they only have served for a period of 24 hours as physicians, are classified Priority IV.

242 doctors have been classified in Priority I. Of this number, 102 are on active duty. 40 have received commissions but have not been called to active duty. 12 have completed a period of service of 24 months. 5 have been examined and found qualified for service but have not been commissioned as yet. 8 have been disqualified on the grounds of personal hardship. As of July 1, 1953, only three will continue to receive occupational deferment for professional reasons. At the present time there are 12 men whose deferment will expire as of June 30. 58 doctors of this group of 242 have been disqualified up until recently for physical reasons. However, there has been such a marked lowering of the physical standards for doctors by the military services that a large number of these 58 will be found physically acceptable for limited military duty.

In the Priority II group, 67 men were registered. Of these 12 are on active duty; 25 have been commissioned but have not been called to duty; 2 have completed a tour of 24 months duty; 2 have been disqualified for personal hardship reasons; 5 are deferred on grounds of professional essentiality. But of these five only two should remain so qualified after July 1. 21 have been physically disqualified. Here again these 21 men are being carefully reviewed and undoubtedly this number will be markedly reduced.

677 doctors in this State have been registered in Priority III and of this number 627 have been classified. Of these, 109 have been found acceptable for service up to the present time. Only 6 however are on active duty. 34 men have not had their records completed; 9 have accepted commissions but have not been called to duty; 8 have been deferred on grounds of personal hardship; 4 have been deferred as ministers of religion; 120 have received occupational deferments of varying periods of time; 37 have reached the age of 51 since they were processed and therefore are disqualified on ground of age; and 290 have been disqualified for physical reasons. This number will surely be reduced a great deal by the new physical standards.

In recapitulation, it can be seen that as of July 1, 1953, of 242 doctors in Priority I, 8 will be deferred for hardship reasons and only 3 will be deferred on professional grounds. My guess would be that no more than 10 of the 58 disqualified now for physical reasons will continue to be disqualified. Therefore, 20 doctors in the Priority I group out of a total of 242 will not be available in this category. In Priority II, 2 doctors will be deferred for professional reasons, 2 for personal hardship, and certainly no more than 5 for physical reasons, which means that of 67 doctors in Priority II, approximately 9 will continue to be deferred.

It is obvious, therefore, that in this State the number of doctors qualified in Priority I and Priority II will soon have been exhausted and, for the future, it will be necessary to call up doctors in Priority III. This class represents the largest group by far. Eventually doctors in Priority IV may be recalled.

Just recently General Hershey, Chief of the Selective Service System, issued an order that no doctor in Priority III born before August 30, 1922, should be called up for service, even though he is professionally and physically qualified. This can only mean one thing, and that is that practically all doctors in Priority I and Priority II will have to enter service in the near future and we would feel that there will be no professional deferments continuing in Priorities I and II after January 1, 1954. Certainly the pressure to have every qualified doctor in Priorities I and II enter the service has become extremely great.

I would call to your attention the fact that of the total number of doctors listed in the various classifications, it cannot be assumed that all of these men are actual residents of this State. Actually, many of them are not residents of this State and therefore the depletion of the physicians available for civilian duties in Maryland is not as great as it would appear. This is due to the fact that when the Civilian Draft Act of 1948 was passed, men qualified to register under the draft at that time had to register in the area in which they were residing, whether they were legal residents of the State at that time or not. No matter where they may live at the present time, they are still subject to the jurisdiction of the draft board under which they registered in 1948 and therefore we find that we are processing doctors who are residing all over this country and some who are in foreign lands. This is accomplished by a close cooperation between the various State medical advisory committees. For example, we do not feel that we should express an opinion on the professional eligibility of a doctor for service, even though he is registered under a Maryland draft board, when he has been residing in the State of Oregon for the past two years. When his name comes to our attention, we immediately correspond with the Chairman of the Oregon State Advisory Committee and forward his opinion to the Maryland draft board concerned. I would also like to call attention to the fact that many of the doctors in Priorities I and II have been, or are receiving periods of hospital internship and would not in the natural course of events reside in Maryland but would leave the State on completion of their training. Therefore, the figures I have presented cannot be used to pass judgement upon the depletion of doctors rendering civilian service in this State. However, this program has resulted in a rather serious reduction in the medical services in this city, especially in the hospitals. I would call to your attention the fact that many of the younger doctors in the Priority III group, who represent men who have graduated from medical school in 1948 up to the present, are receiving periods of hospital training and that would account in large measure for the high percentage of doctors deferred in the third priority. The loss of the older doctors in the Priority III group to the military services will undoubtedly cause real hardship in civilian communities. The Maryland Advisory Committee has felt that all doctors who were deferred from military service in World War II should now be considered eligible for military service practically without exception. However, because we have declared these men eligible for military service, it does not necessarily imply that they should all enter the service at one and the same time. They should be called up for service in a carefully prescribed manner. At the present time it has been the policy of the National Advisory Committee to advocate that doctors in Priority III group should be called into service by age groups. This would certainly seem to be a fair and reasonable method. During the past few months, however, the Selective Service System began to call up doctors in the Priority III group up to 38 years of age and not by age groups. Fortunately the recent order of General Hershey, referred to above, stopped this process and at least four doctors in Maryland from 36 to 38 years of age were spared from entering the service before much younger doctors in the same priority had been called up.

It might be of interest to note that there are three conscientious objectors classified in Priority I in this State and two of these already have been assigned to civil service jobs, whereas the third one has been delayed because of his age. At the present there are two aliens registered in this State in the Priority III group, who may or may not be called into service.

I would like to call to your attention that the Chairmen of the State Advisory Committees are writing to every doctor who is about to be released from his period of military service offering to assist him in any way possible to obtain further postgraduate training or to find a location in which to practice. This program has been instituted in conjunction with the American Medical Association during the past year.

In conclusion, I think it can be readily seen that the Maryland Advisory Committee has carried out the terms of Public Law 779 in an effective manner, and I do not feel that there are very many doctors qualified for military service in the first and second priorities who have been deferred from service unjustly. We have tried to be as fair as possible, yet firm. We can only ask your cooperation and your support for this program, which must be considered to be at best an onerous, burdensome thing for a doctor to comply with, requiring real sacrifice, both financial and professional. However, it is the price we have to pay today to survive as a free nation in these turbulent times.

Respectfully submitted,
R. Walter Graham, Jr., M.D., *Chairman*

COMMITTEE FOR BETTER DISTRIBUTION OF DOCTORS THROUGHOUT THE STATE

Mr. President and Members of the House of Delegates:

The Committee for Better Distribution of Doctors Throughout the State of Maryland has had no meeting since its appointment, as a preliminary study of the problem of the Chairman indicated that the charge made to this Committee was a tremendous one with perhaps more connotations than were at first realized by the originators of the idea. However, both of these factors indicate that there *is* a problem, that it involves many facets of medicine in Maryland, and the solution will require much investigation, planning and public-relations' work for some years to come, if the experience of other States is any indication.

Statistical information must be collected as to:—the actual number of physicians in Maryland, where they live and their types of practice; the needs and facilities of each community and what each can and will do to attract doctors and to keep them; ways and means to increase and improve these facilities, and many other facets of the problem which will develop as progress is made.

As stated above, a review of the activities of four States indicates that the Committee appointed by President Chesney in October, 1952 might be expected to act in a motivating and advisory capacity, but that facilities and personnel will need be established to collect and organize factual data, to implement and distribute information, and to staff a permanent bureau for future usefulness and activity in all respects. To initiate the project it would seem that one full-time person should be employed with secretarial assistance (latter will probably become full-time need in a short time). Later, funds for travel in the field and even to other States will be needed as well as for expansion of the central office as becomes necessary.

The proper development of this project might well be one of the most valuable and far reaching services of the Medical Faculty of Maryland to the State of Maryland. The Committee requests further direction as to how it should proceed.

Respectfully submitted,
Allen F. Voshell, M.D., *Chairman*
E. I. Baumgartner, M.D.
A. M. France, M.D.
I. Rivers Hanson, M.D.
Richard T. Shackelford, M.D.

COMMITTEE TO STUDY LEGISLATIVE AND PROFESSIONAL STANDARDS AND STAFF RELATIONS OF HOSPITALS

Mr. President and Members of the House of Delegates:

At the semi-annual meeting of the Medical and Chirurgical Faculty of the State of Maryland in Ocean City, it was decided that a Committee should be appointed to study the possibilities of a better hospital licensure law.

This committee was appointed by Dr. Chesney consisting of Dr. Merrell L. Stout, Dr. William H. F. Warthen, Dr. Ernest I. Cornbrooks, Jr., Dr. Russell A. Nelson and Dr. Ross Z. Pierpont. The committee has held numerous telephone conferences individually and two full meetings. All of the aspects of the situation were carefully gone over and to summarize briefly the committee felt that while the Medical Practices Act and the Blue Cross might be ancillary facilities as far as hospital control is concerned, that the problem could not be solved in either of these situations. It was finally decided that the hospital licensure law was the only place in which real control could be built into the problem.

A careful study of the law in this and other states revealed the fact that our law is essentially a good one, except for the fact that one very large loophole, with regard to professional staffs, is present. In looking further we found that the original law, which was presented to the legislature in Section 496G read as follows: "The State Department of Health shall have full power and authority to make and promulgate reasonable rules and regulations classifying hospitals and prescribing minimum standards of safety and sanitation in the physical plant, of diagnostic, therapeutic and laboratory facilities and equipment of each class of hospitals, and minimum qualifications or training of the professional staffs for each class of hospitals, provided, however, that nothing contained in this Sub-title shall affect the right of each institution to employ its own personnel and staff, . . ." However, the Medical and Chirurgical Faculty had the following removed: "minimum qualifications or training of the professional staffs for each class of hospitals."

This committee now feels that this provision should be replaced in the law since we believe the professional staff of any hospital is one of the most important elements of that hospital's satisfactory performance. Although some may have apprehension that this being administered by the State Department of Health might create an undesirable setting of control by a state agency of professional activities in a hospital, we do not believe that this will follow. On the contrary, The Maryland State Department of Health, through the Board of Health, has adequate representation of the practicing medical profession of the state. Furthermore, we recommend that in the administration of the hospital licensure law, with the added feature of setting standards for professional staff, the State Board of Health establish an advisory committee from the Medical and Chirurgical Faculty of the State of Maryland. If this recommendation is followed out, the Medical Faculty would have a direct access to advise the State Board of Health on hospital licensure.

The committee further recommends to the House of Delegates that these members from the Medical and Chirurgical Faculty be a combination of appointive and elective members.

The chairman wishes at this time to express his gratitude for the extended effort of all members of the committee and we are all, I am sure, grateful to Mr. Kirkman for his sound counsel and advice.

Since this concludes our efforts, we respectfully submit this report and ask for our discharge at this time.

Respectfully submitted,
Ross Z. Pierpont, M.D., *Chairman*
Ernest I. Cornbrooks, Jr., M.D.
Russell A. Nelson, M.D.
Merrell L. Stout, M.D.
William H. F. Warthen, M.D.

COMMITTEE TO STUDY AN INSURANCE PROBLEM

Mr. President and Members of the House of Delegates:

The Committee to Study an Insurance Problem consisting of Doctors William L. Garlick, Alexander J. Schaffer and John Parsons has met and submit the following report:

The Committee wishes to restate that it was appointed to suggest a method for the collection of large sums of money for medical services rendered by resident physicians in hospitals, which were being left in the hands of prepaid medical insurance companies and being lost to the medical profession. The Committee made two suggestions—

1. *that such monies be collected by a private physician having accepted that patient as his own,*
2. *that such monies be collected by a physician authorized by the board of governors of an institution and to be placed in a fund to be used at the discretion of that professional board.*

These suggestions have been carried out by the majority of the hospitals in the city. Large sums of money have been placed in funds set up by these hospitals for the further training of their resident staff. The problem is peculiar to the hospitals in the City of Baltimore rather than to any of the county hospitals. The major portion of such funds have come from the Maryland Medical Service, Inc., i.e., Blue Shield. There has been only the occasional patient with other than non-profit insurance (such as Blue Shield) from whose insurance company such monies have been collected. The Committee obtained from the Maryland Medical Service, Inc., the following report of payments made to special funds established for furtherance of graduate medical education in all the institutions where such funds had been established and reported to it. It is to be noted that none of the Catholic hospitals appear on this list. It is the understanding of the Committee that some of the Catholic hospitals have recently established such funds. It is to be noted that about 85% of these payments have been made under the special surgical program for the Bethlehem Steel. It is believed that in large part these payments are for services rendered to Negro patients. These figures are for the year 1952. One factor in the collection of fees in the Baltimore City Hospitals has been the work done in poliomyelitis.

MARYLAND MEDICAL SERVICE, INC.

Payments made to Hospitals for Services Rendered to Blue Shield Subscribers by Members of Resident Staff, Where Special Fund Established for Furtherance of Graduate Medical Education.

Year 1952

	Standard	*Bethlehem Steel*	*Total*
Baltimore Eye, Ear and Throat Hospital	$ 30.00	$ 150.00	$ 180.00
Church Home and Hospital	109.69	3,457.50	3,567.19
Franklin Square Hospital	—	100.00	100.00
Women's Hospital	514.00	2,315.00	2,829.00
Johns Hopkins Hospital	5,265.21	41,279.50	46,544.71
Sinai Hospital	673.89	3,110.00	3,783.89
South Baltimore General	—	60.00	60.00
Union Memorial Hospital	318.75	—	318.75
Baltimore City Hospitals	1,387.69	13,202.50	14,590.19
	$8,299.23	$63,674.50	$71,973.73

(March 1953)

The payments made to these hospitals constitute approximately 7% of Blue Shield total payments for care to all subscribers in 1952.

In January, 1953 the Baltimore City Medical Society passed the following resolution:

> "*Whereas, it has come to the attention of the Baltimore City Medical Society that the Maryland Medical Service, Incorporated, is paying professional fees on behalf of some of its subscribers who are being rendered care by the Resident Staffs of Maryland Hospitals, be it resolved that the Baltimore City Medical Society is in favor of the payment of such professional fees into special funds established for the purpose of postgraduate training, provided that such funds be under the control of the professional staff advisory board of the institutions concerned.*
>
> "*Be it further resolved that the delegates of the Baltimore City Medical Society to the House of Delegates of the Medical and Chirurgical Faculty of Maryland be instructed to propose and support the principle of the foregoing resolution in the House of Delegates at the Annual Meeting.*"

The Committee quote from its original report of 1951:

"It is recommended that such hospitals establish an authorized officer, a physician, to collect such fees, and monies so obtained to be used as their board of governors deem advisable."

The Committee hence approves of the resolution of the Baltimore City Medical Society of January 16th, 1953.

One further problem was considered during the year. The American Health Insurance Corporation through Mr. W. deV. Washburn, its president, sent the enclosed letter to the chairman of the Committee after various telephone conversations, the essence of the letter being that the insurance company questioned payment on a claim where the policy benefit had been assigned to a hospital. The letter follows:

AMERICAN HEALTH INSURANCE CORPORATION

First National Bank Building
Baltimore 2, Md.
November 5, 1952

Dr. William L. Garlick
700 North Charles Street
Baltimore, Maryland

Dear Dr. Garlick:

In accordance with our conversation some time ago, here are the facts for your file in connection with an actual case that typifies the "Insurance Problem" which your Committee has been asked to study for the Faculty.

In this case, our policyowner is a 62 year old colored tenant farmer from a rural Southern Maryland county. Economically, I would place him well down in the income brackets. He is not eligible for group insurance by reason of his employment status or otherwise. I would say that politically he is the type of voter to whom compulsory health insurance and socialized medicine might appeal strongly, particularly when "given" by a paternalistic government. In trying to spread and perfect voluntary health insurance, this is probably the most difficult type to cover successfully, because of the combination of rural location, low cash earnings and non-affiliation with a group.

In November of 1950, following the extensive advertising appeal made by the A.M.A. to buy health insurance "the voluntary way," this man was persuaded by one of our agents to insure himself and his dependents under a family policy to become effective December 1, 1950. The expense limits provided by his policy were based on $6.00 daily hospital room charges and included related "extras," and also included a surgical procedure fee schedule ranging between $10.00 and $200.00. These limits are probably substantially in excess of amounts usually collected from this type of patient by the hospitals and doctors in his community. We permitted him to pay his premiums monthly to our agency office at Hughesville, but the monthly premium of $6.00 was still to him an undoubtedly large amount.

This year he was admitted to a Baltimore Hospital as a ward patient with a recent history of recurrence of gross hematuria, diurnal and nocturnal frequency and a very slow stream, symptoms which had previously been cleared up by operation and treatment. Apparently he was not referred to the hospital by a physician.

When we received the claim form it showed that policy benefits had been assigned to the hospital.

With the claim form was a bill from the hospital for $588.10, representing 16 days room charge at $13.00 daily, $180.00 of other hospital charges, and "Professional Fee"—$200.00. *It was accompanied by a "Hospital Report" indicating that a perineal prostatectomy had been performed and showing the doctor's name. Our claim adjuster was faced with several questions:*

(1) Should the claim be honored without investigation, since we do not accept liability (except for group policies) for conditions known to the applicant to exist when coverage is applied for?

(2) Should we pay the allowance for surgeon's fee to the hospital?

He checked further and decided to honor the claim although the condition requiring care had existed prior to our policy and had been known to the applicant, as he felt the policyowner had purchased our policy in good faith upon the recommendation of our agent and of a local doctor whom he had asked about our Company.

In the course of his checking, he found that the hospital was looking to the patient or his son for payment of the portion of its bill not covered by insurance.

The second question is not so easily answered. Should we pay the hospital the amount allowed for expense incurred for a surgical operation?

Our policy specifically states "the physician-patient relationship shall be maintained." This statement is not inserted primarily to protect the doctors' pocketbooks. It is there because the contract affects the doctor and patient when a claim arises and we do not want either of them or the public to be affected adversely by a legal instrument we prepared.

I don't believe control by hospitals of the practice of medicine would be preferable to socialized medicine in the long run. It would make for even less feeling by the doctor, of personal responsibility for the individual patient, which I believe is the priceless ingredient in the so-called physician-patient relationship. I don't believe the doctors should want hospitals billing and collecting from insurance companies for operations. If we insurers acquiesce in such practices, are we acting in the public interest?

This question of who collects the fee, it seems to me, is the crux of the problem of maintaining the personal touch between doctor and patient. It would not be a realistic appraisal of human incentives to think otherwise.

It is our understanding that for a number of years the A.M.A. and the American Hospital Association have agreed that hospital-physician financial arrangements be left for settlement on a local basis.

Hence we are asking the Faculty whether it is ethical in Maryland for a hospital to bill us and for us to pay it for performance of a surgical operation. Specifically, does such a practice "maintain the physician-patient relationship"?

If this is over-simplified, the problem might be broken down into an examination of the propriety of hospitals in Maryland billing, and insurers paying them for, professional services performed by:

(1) Internes.

(2) Teaching doctors, for a ward patient paying a substantial part of his hospital bill, where the operation is used in "demonstrating."

(3) A salaried doctor who, by reason of contract with a hospital, school or governmental body, is not permitted to practice privately for remuneration.

It should be obvious that, because insurance costs to the public depend directly upon claim payments, acceptance of such billings by insurers ultimately means payment of them by the insuring public, with the insurer only an intermediary in the process. Naturally, if we pay the hospitals, we will charge the public.

If further comments will be helpful, please advise.

Cordially,
W. deV. Washburn (Signed)
W. deV. Washburn
President

WW:RMC

Several factors were involved, (1) the semi-private or ward patient who seeks services covered by commercial insurance, (2) such services rendered by a house physician supervised by a full time salaried physician of a teaching staff.

The Committee recommends that all such commercial insurance fees be collected in the same manner as the nonprofit insurance, i.e., (1) by the physician who accepts the responsibility of the patient or (2) by an authorized officer, a physician, to go into a fund for furtherance of graduate medical education.

The Committee wishes to call attention to the profound sociological effect of big industrial companies affording medical coverage for its workers and their families as in the case of the Bethlehem Steel Special Plan and that immediate effect on medicine, as shown in this particular problem.

Respectfully submitted,
William L. Garlick, M.D., *Chairman*
John W. Parsons, M.D.
Alexander J. Schaffer, M.D.

COMMITTEE FOR THE STUDY OF CERTAIN PHASES OF MEDICAL ECONOMICS

Mr. President and Members of the House of Delegates:

The following recommendations by the committee were adopted by the House of Delegates of the Medical and Chirurgical Faculty at the annual meeting on April 28, 1952. They recommended that the Medical and Chirurgical Faculty in conjunction with other interested groups, prepare and sponsor a bill, incorporating the following ideas, to be presented to the Maryland Legislature at the 1953 session.

1) The cost and compensation for time lost during the training period be deductible from income tax over a suitable number of years.

2) Postgraduate and advanced training be deductible.

3) Setting up of a retirement plan taxable only on payment, which would allow an individual to prepare during his active years for his declining years.

On October 10, 1952 the above committee was asked to prepare such a bill and present it to the Maryland Legislature in 1953. The members of the committee felt that it was too late to prepare such a bill and get the necessary ground work done by the component societies, in order to get any consideration by the 1953 Legislature. The Council was so informed and invited the Chairman, Dr. Moyers, to the meeting of December 2, 1953. At that meeting the following action was taken and is quoted from the Council Minutes:

"*Dr. Moyers stated that it would be impossible to present an appropriate bill in time for the 1953 session, and recommended that further study be made of the problem with the idea of presenting a bill, incorporating the suggestions of the Committee, at a subsequent meeting of the State Legislature. Upon motion of Dr. Pincoffs, it was approved that presentation of a bill to the Maryland General Assembly be postponed for another year and that the House of Delegates be so informed at its annual session in April 1953. Meanwhile, it was suggested that Dr. Moyers present the problem for review at the 1953 Annual Meeting of the House of Delegates for reaffirmation, and for discussion of a draft of the law to be presented.*"

Since such legislation could not be introduced until the next regular meeting of the Legislature in 1955, and since two of the three recommendations are now under consideration nationally, it would seem wiser for the Medical and Chirurgical Faculty to give its full support to the efforts now being made. The setting up of a retirement fund is before Congress now and it is extremely important that the members of the Medical and Chirurgical Faculty of Maryland contact their representatives and senators and inform them of the merits of these bills and the crying need for such legislation. The House of Delegates of the American Medical Association has approved the principle of these bills, and are eager to have our assistance in promoting them in Congress.

The Jenkins (Reed)—Keough Bills, H.R.10 and H.R.11, which were introduced in the 83rd Congress on January 3, are an attempt to solve the income tax discrimination against the self-employed persons (eleven million in all) in the matter of provision for retirement years. These bills would permit a self-employed person to deduct 10% of his earned net income or $7,500, whichever is smaller, from gross taxable income, provided that the money is invested in a restricted retirement fund or a restricted retirement annuity.

The following quotation from a letter from J. W. Holloway, Jr., Director of the American Medical Association Bureau of Legal Medicine and Legislation stated the present effort to change the status of postgraduate study.

"As you may know there has been in existence, a considerable number of years a ruling by the Office of the Commissioner of Internal Revenue in Washington that expenses incurred by a physician in pursuing postgraduate study are personal in nature and therefore not deductible for federal income tax purposes. We have on a number of occasions made efforts to induce the Commissioner to reverse this ruling but have met with no success. About a year ago we employed special tax counsel to prosecute this matter for us and it was at that time discovered that there was pending before the United States Tax Court a case involving a lawyer who had claimed as a deduction certain expenses he incurred in attending a course on taxation in New York. On advice of our tax counsel we filed a brief as amicus curiee with the Tax Court in support of the contentions made by the lawyer in this case because the principle involved was the same as the one involved in the right of a physician to deduct similar expenses. The Tax Court in a very unconvincing opinion held against the lawyer and the case has been appealed to the United States Court of Appeals, 2d. Circuit, and a hearing on the appeal has been scheduled for March 11. Our tax counsel has filed a brief in this appeal case and will actively participate in the oral presentation before the appellate court."

The recommendations for the deduction for expense and time lost in long time training programs brings up many problems and will need further study. It will probably be best to wait on this one and concentrate on the other two.

Do you think it would be a step in the right direction for the Medical and Chirurgical Faculty of Maryland to go on record as supporting Bills H.R.10, and H.R.11 and so inform the Maryland Senators and Congressman? Also would it not be good to commend Mr. Holloway, Jr., Director of the American Medical Association Bureau of Legal Medicine and Legislation on his effort to change the ruling on postgraudate education?

This report briefly summarizes the present legislation pending on income tax problem. The Chairman has much more detailed information if any one wishes it.

Respectfully submitted,
Waldo B. Moyers, M.D., *Chairman*
Wolcott L. Etienne, M.D.
Houston S. Everett, M.D.
Thomas K. Galvin, M.D.
Frank J. Otenasek, M.D.

COMMITTEE TO COOPERATE WITH AMERICAN MEDICAL EDUCATION FOUNDATION

Mr. President and Members of the House of Delegates:

To the sound of good wishes sent to the American Medical Education Foundation by President Eisenhower the meeting of the Foundation and its national representatives (state chairmen, etc.) opened in Chicago, January 25, 1953. This meeting was a review of the efforts of the various states for the year 1952, closing December 31. At that time prior to January 25, 1952, Maryland had eighty-seven contributors with a total contribution of $5,713.00. These figures do not include contributions made directly to the medical schools, some of which may be a result of the efforts of the Foundation program. Nevertheless, only monies that actually passed through the Foundation's hands were credited to the Foundation. It was again emphasized in this meeting that the National Foundation's (lay organizations) contingent funds, that is those funds which will be used to match contributions of doctors to the American Medical Education Foundation, can only be used to match monies that come *through* the Foundation. It is hoped, therefore, that regardless of how the contributions were made to the medical school that ultimately a check for the total contributions received by the Alumni Association of Medical Schools will be sent annually to the American Medical Education Foundation and naturally to be earmarked back to that school that sends the check. This would in no way interfere with the administration by the school of the direct contributions. The total fund of the American Medical Education Foundation to be matched by contingent funds hence would be swelled.

The Chairman wishes to thank the Editor and secretarial staff of the State Journal for their splendid cooperation in connection with publicity for the program, and also the Faculty office staff for their accurate recording of the tally and prompt acknowledgements of all contributions. Hearty thanks go to our Committee, who have served well this past year. To the new members of the Committee, whose names are listed herein, I bid you welcome and am looking forward to a big year with your help. Our goal this year is two million dollars from all states to the American Medical Education Foundation. The past year saw us over the one million mark.

In general, mail solicitation proved the least effective and person to person solicitation plus personal appearances at nine of our twenty-two component societies by the Chairman seemed to be of greater value. Heavy emphasis will be given this type of approach in enlarging our Committee this year. Correspondence has been maintained with the presidents of all twenty-two societies with a courteous response from most. Thanks goes to those societies who were hosts at dinner to Committee speakers.

May I still suggest that eighty-seven contributors to such a vital project in behalf of the entire medical profession is still a small number in a society that acknowledges over eighteen hundred members. We need lots more of the loyal supporters such as Dr. Harvey Stone, who will receive the American Medical Education Foundation Award of Merit for his generous contributions.

Respectfully submitted,
Newland E. Day, M.D., *Chairman*
Thurston R. Adams, M.D.
Walter E. Baetjer, M.D.
John G. Ball, M.D.
J. H. Bates, M.D.
Katherine A. Chapman, M.D.
Stuart Christhilf, Jr., M.D.
H. V. Davis, M.D.
Wilfred W. Eastman, M.D.
Charles R. Foutz, M.D.
J. Stanley Grabill, M.D.
Donald B. Grove, M.D.
William B. Hagan, M.D.
L. A. Hoffman, M.D.
Philip A. Insley, M.D.
W. O. McLane, Jr., M.D.
Ernest F. Poole, M.D.
Paul H. Royse, M.D.
Theodore R. Shrop, M.D.
M. H. Sprecher, M.D.

ARMY MEDICAL LIBRARY COMMITTEE

Negative Report.

Andrew C. Gillis, M.D., *Chairman;* Drs. J. T. King, J. E. Savage, L. R. Wharton, S. Wolman.

BLOOD BANK ADVISORY COMMITTEE

Mr. President and Members of the House of Delegates:

In accordance with your request I have the honor to submit the report of the Blood Bank Committee of the Medical and Chirurgical Faculty of the State of Maryland. The President of the Faculty requested that your Committee investigate the problem of the availability of blood to the various county hospitals and to see what unmet needs there were in these institutions.

Sixteen hospitals were contacted (see appended list) with a total of 1,491 beds and covering we believe the entire State, with the exception of Baltimore City and the Washington suburban area. Two hospitals were visited in person by a member of this Committee, namely the Anne Arundel County General in Annapolis and the Peninsula Hospital in Salisbury. The remainder were sent a letter, copy of which is enclosed.

All but three hospitals signified that they had a reasonably adequate supply of blood for their normal needs and that no supplementary supply of blood was necessary.

The three institutions which stated that they had an insufficient supply of blood were Prince Frederick (32 beds), Crisfield (38 beds) and Easton (108 beds). The hospital at Easton also voluntarily stated that while they needed more blood, they wished to have no part in any Red Cross program (which in the opinion of the Committee would be about the only logical blood course).

In the light of the above facts, since only 178, or less than 12% of the 1,491 beds covered, saw a need for additional blood, your Committee felt that a statewide campaign for additional blood was not in order and that the three institutions needing more blood should be urged to contact the other hospitals in their vicinity to arrange for increased bleeding of local donors in their respective areas. Specifically Crisfield and Easton could lean toward Cambridge and Salisbury for help and Prince Frederick toward Annapolis.

Your Committee also was appointed to represent the Medical and Chirurgical Faculty in negotiations with the Red Cross on various matters pertaining to blood, and met with the Blood Program Committee of the Red Cross at a recent date and learned at that time that the Red Cross Blood quota for the Baltimore Chapter had been substantially increased, due to the fact that the Office of Defense Mobilization was anxious to obtain gamma globulin for administration in polio. Your Committee questioned the advisability of increasing the Red Cross quota and publicizing the use of gamma globulin for two reasons, one was that it did not know what effect this would have on civilian hospital blood banks in this area and two, that it felt the impact of the gamma globulin publicity might be a serious one next summer when the "polio season" starts in this area.

The Committee wrote to the Council of the Medical and Chirurgical Faculty on February 6 expressing its reservations concerning this program and asked for an opinion from the Council as to how it felt in the matter.

Respectfully submitted,
Merrell L. Stout, M.D., *Chairman*
C. Lockard Conley, M.D.
Kendrick McCullough, M.D.
Walter C. Merkel, M.D.
H. Raymond Peters, M.D.
Milton S. Sacks M.D.
Benedict Skitarelic, M.D.
John Whitridge, Jr., M.D.

(*Appended list referred to in Blood Bank Advisory Committee Report.*)

THE HOSPITAL FOR THE WOMEN OF MARYLAND
BALTIMORE 17, MARYLAND

MERRELL L. STOUT, M.D., DIRECTOR

January 29, 1953

Dear Administrator:

While realizing that there are times when no hospital has sufficient blood available, do you feel that on the average at present your blood needs are being met?

If not, and additional blood could be supplied to you without cost, from a central source, do you feel you have sufficient trained technical personnel available to cross-match and administer additional quantities?

We would appreciate your checking the appropriate boxes at the bottom of this page and returning this letter to us in the enclosed self-addressed stamped envelope.

Very truly yours,
Merrell L. Stout, M.D.

Chairman, Blood Bank Committee of the
Medical and Chirurgical Faculty of Maryland
Sufficient blood *yes* ☐ *no* ☐
Sufficient personnel *yes* ☐ *no* ☐

Hospital	*No. of beds*
Prince Frederick	32
Crisfield	38
Easton	108
Annapolis	70
Salisbury	200
La Plata	40
Havre de Grace	72
Cambridge	78
Frederick	125
Garrett County	37
Memorial, Cumberland	217
Allegany, Cumberland	134
Frostburg	51
Elkton	75
Hagerstown	184
Chestertown	30
	1,491

February 6, 1953

CANCER COMMITTEE

Mr. President and Members of the House of Delegates:

As in former years the vast majority of the cancer work in the State of Maryland has been accomplished by the Maryland Division of the American Cancer Society. The work has progressed in general as in former years and detection centers are now in operation in every county except Allegany and Garrett; the last detection center was installed in Somerset County. This year there were 3,690 examinees compared with 3,728 in the previous year. There were ten cancers diagnosed at the time of the original examination, nine of which were cancer of the cervix and one a cancer of the lip in a man. The cost of finding a cancer patient in the detection center, is approximately $1,000; it is interesting to note that the cost has not changed materially in the past several years. This figure does not include the treatment of the patient.

During the course of the latter portion of the year the question of the value of detection centers was discussed and as a result of this a committee was appointed to consider the problem. They will report later to the Executive Committee of the Cancer Society with a view to undertaking some other program in place of detection centers. In regard to continuing the detection centers, I feel that they should be continued at this time for this is one tangible asset that is provided to the layman.

The pathological services, sponsored by the Society, at the Johns Hopkins Medical School and University Hospital, have continued to operate. A total of 2,349 biopsies were studied.

The Maryland Division of the Cancer Society has expended $40,000.00 for grants-in-aid for cancer research. This is an amount similar to that spent in the preceding year. In addition to the above $5,150 was disbursed for grants-in-aid for service projects which have been established in various hospitals.

The Committee for the Study of Pelvic Cancer was formed; this committee, which is an official committee of the Medical and Chirurgical Faculty of the State of Maryland, is financially supported by a grant from the Maryland Division of the American Cancer Society.

Financial assistance to the medically indigent patient has also been carried out. This included an appropriation for surgical dressings. During the year 156 individuals were aided directly; in addition to this, by assistance of the Visiting Nurses Association 59 additional patients were helped, making a total of 215 individuals aided. The exact number of paitents helped through the dressing program is not known.

We are indeed fortunate in having such an active and successful division of the Cancer Society which has made great progress and accomplished much in the past few years.

The Cancer Committee of the Medical and Chirurgical Faculty has existed for a number of years with a very large personnel. Due to the fact that the committee has never met as a whole I would suggest that its membership be greatly diminished so that the activities could be carried on by the

Chairman and five or six interested members. If the future need arises the membership may be augmented.

Respectfully submitted,
J. Mason Hundley, Jr., M.D., *Chairman*
C. Bernard Brack, M.D.
L. H. Brumback, M.D.
L. Clarence Cohn, M.D.
Beverley C. Compton, M.D.
William K. Diehl, M.D.
Everett S. Diggs, M.D.
Wylie M. Faw, Jr., M.D.
Gerald A. Galvin, M.D.
Howard W. Jones, Jr., M.D.
James T. Marsh, M.D.
William Neill, Jr., M.D.
William D. Noble, M.D.
Arthur G. Siwinski, M.D.
Edwin H. Stewart, Jr., M.D.
Richard W. TeLinde, M.D.
James B. Thomas, M.D.
Grant E. Ward, M.D.

COMMITTEE ON CONSTITUTION AND BY-LAWS

Mr. President and Members of the House of Delegates:

When you read the Constitution and By-Laws of the Medical and Chirurgical Faculty of the State of Maryland and think of the date of Incorporation, January 20, 1799 (154 years ago) and the date of Adoption, April 26, 1904 (nearly 49 years ago), you are forcibly impressed by the wisdom and thoroughness written into this document which has been used to govern our State Society these many years.

The Committee last appointed to revise the Constitution, consisting of Dr. Lawrence R. Wharton, Chairman, and Drs. Clewell Howell and John T. King, have certainly very ably brought the Constitution up to date with the most recent amendments as of April 1952.

Your present Committee, being composed of Dr. W. Houston Toulson, Dr. E. Cowles Andrus, Dr. Donald H. Hooker, and myself, have held several conferences and meetings. We have been fortunate to have Drs. Chatard, Yeager, Wharton and Diggs meet with us. In view of the growth of our Society, whose membership now numbers 2,451, and perhaps to keep up with our changing world, we submit to the House of Delegates for its approval several additional changes in our State Constitution.

Some of the suggestions and recommendations were referred to the Committee by action of the House of Delegates at its meeting in September 1952. Other amendments were suggested by the Council of the Medical and Chirurgical Faculty.

AMENDMENTS
CONSTITUTION AND BY-LAWS
CONSTITUTION

(Amendments appear in CAPITAL LETTERS)

ARTICLE XIV—Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the Delegates present at any Annual Session, provided that such amendment shall have been presented in open meeting at the previous annual, semi-annual session or special session, and that it shall have been sent officially to each component society at least two months before the meeting at which final action is to be taken.

The following amendments to the Constitution will be presented to the House of Delegates on Tuesday, April 28, 1953, but final action cannot be taken until the Annual Meeting of the House of Delegates in 1954.

ARTICLE V—House of Delegates

Section 2.

The House of Delegates shall consist of (1) delegates elected by the component societies, each component society being entitled to elect one delegate for each 50 active members in good standing, or major fraction thereof; provided each component society shall be entitled to elect at least one delegate; (2) the membership of the Council; (3) ex-officio, the President, the incoming President, the immediate past President, the Chairman of the Library Committee, the delegates to the House of Delegates of the American Medical Association; and (4) one member elected by the State Board of Medical Examiners.

Amendment:

Delete: (3) EX-OFFICIO, THE PRESIDENT, THE INCOMING PRESIDENT, THE IMMEDIATE PAST PRESIDENT, THE CHAIRMAN OF THE LIBRARY COMMITTEE, THE DELEGATES TO THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION: AND

Change: Number (4) to read (3)

Explanation: This Section has been deleted on recommendation of the Council as ARTICLE VI, Section 2, contains this information. Take note, in this Section, that the following has not been amended: "one member elected by the State Board of Medical Examiners."

ARTICLE VI—Council

Section 2.

The Council shall consist of (1) fifteen Councilors; and (2) the President, the immediate past President, the President-elect, the Secretary, the Treasurer, and the Chairman of the Library Committee, and Delegates to the American Medical Association House of Delegates, AND CHAIRMAN OF THE COMMITTEE ON CONSTITUTION AND BY-LAWS.

Amendment:

Delete: AND (after Treasurer)
AND (after Committee)

and add final clause as noted in Capital Letters above.

ARTICLE VII—Officers

Section 3.

All officers, except Councilors, shall serve a term of one (1) year. The term of the Councilors shall be for three (3) years from the date of their installation into office, PROVIDED HOWEVER THAT NO COUNCILOR MAY SERVE MORE THAN TWO (2) CONSECUTIVE ELECTED TERMS.

Explanation: The Resolution presented and adopted by the House of Delegates September 1952, regarding terms of Councilors, will be recalled. "Be it Resolved that the Baltimore County Medical Association recommends that the elected members of the Council of the Medical and Chirurgical Faculty of the State of Maryland be limited to two (2) consecutive terms."

ARTICLE VIII—Sessions and Meetings

Section 2.

Special meetings of either the Faculty or the House of Delegates may be called by the President or on petition of 10 delegates or 20 members respectively.

Amendment:

Change: Figure "20" to read: "50"

Explanation: At present, the membership is approximately 2,451 and there are approximately 79 members of the House of Delegates. Our Committee called attention to ARTICLE VIII, Section 2, pertaining to Sessions and Meetings and questioned whether twenty (20) members is not too small a number to petition for special meetings of either the Faculty or the House of Delegates, in view of the growth of the Medical and Chirurgical Faculty, and recommended that the figure be changed to fifty (50).

ARTICLE XI—Funds and Expenses

Section 2.

Funds may also be raised by such special assessments on members as the House of Delegates, OR IN THE INTERIM OF HOUSE OF DELEGATES MEETINGS THE COUNCIL, may determine; by voluntary contributions, devises, bequests and other gifts; by sale of the Faculty's publications, or in any other manner approved by the House of Delegates.

Note Amendment: or in the interim of House of Delegates Meetings the Council

BY-LAWS

(Amendments appear in CAPITAL LETTERS)

CHAPTER XI—Amendments

These By-Laws may be amended at any Annual Meeting of the House of Delegates by a majority vote of all the delegates present at that session, after the amendment has laid on the table for one day; or at any Semi-Annual Meeting by a majority vote of all the delegates present at that session, providing the amendment has been sent officially to all the delegates at least 30 days prior to the Semi-Annual Meeting.

The amendments to the By-Laws are being presented today, and as indicated in Chapter XI, these amendments may lay on the table for one day and final action will therefore be taken on Wednesday, April 29, 1953.

CHAPTER II—Dues and Assessments

Section 1. *Active Members.* Funds shall be raised by per capita dues to be paid by every member of the component societies. The amount of the dues shall be $20.00 per capita per annum for active members in the County Societies and $35.00 for active members of the Baltimore City Medical Society, with the following exceptions:

a. In the County Medical Societies the following rates shall prevail: for the first year in private practice the dues shall be $10.00 per annum; for the second year, $15.00; and the third year and thereafter, $20.00.

b. In the Baltimore City Medical Society the following rate shall prevail: for the first year in private practice the dues shall be $15.00 per capita per annum; for the second year, $25.00; and the third year and thereafter, $35.00.

c. As long as a physician is on the resident staff of a hospital or fellowship and not in private practice, his dues for membership in either the Baltimore City Medical Society or the County Medical Societies shall be $2.50.

d. The dues of a licensed physician in Maryland who holds an academic position on a full time salary basis, other than as a fellow or house officer, shall be $15.00 per annum during the first five years of his academic position.

Such per capita assessment is to be included in annual dues of the individual member as paid to his component society; and any member paying dues in each current year prior to ten days before the Annual Meeting is to be considered an active member. However, it is herein exacted that only active members, whose dues have been paid in advance, prior to January thirty-first, of each current year, will be eligible for the provision of Physicians' Defense.

Section 2. *Associate Members.* The annual dues for associate members shall be $15.00 per year, and shall be payable January 31, in advance, with the following exception: The Treasurer of the Baltimore City Dental Society shall pay to the Treasurer of the Medical and Chirurgical Faculty each year the sum of $3.00 as annual dues for each of its members who shall be designated as associate members. The Treasurer of the Baltimore City Dental Society shall also pay annually to the Medical and Chirurgical Faculty the sum of $50.00 for the purchase of dental books and journals.

Section 3. *Non-Resident Members* shall pay $5.00 dues per annum directly to the Treasurer and shall receive all notices and publications.

Amendments:

Section 1. *Active Members.*

Change: $20.00 to read $30.00

Change: $35.00 to read $45.00

Section 1. a. Change: $20.00 to read $30.00

Section 1. b. Change: $35.00 to read $45.00

Section 1. d. To be deleted

Section 1. (Last Paragraph)

Change: The words "assessment is" to read "DUES ARE"

Explanation: This recommendation is made at the request of the Council to meet necessary operating expenses. The Faculty has had to spread into new and larger offices, additional help is needed and as is well known, wages have increased elsewhere. As our Treasurer has pointed out, "were it not for our loyal staff holding on, we would fold up." The Medical and Chirurgical Faculty of Maryland should have a much broader economic base on which to build.

CHAPTER IV—House of Delegates

Section 2.

Twenty members IN ATTENDANCE, of the House of Delegates, shall constitute a *quorum*.

CHAPTER VII—The Council

Section 6.

(c) The Council shall not undertake the defense of any suit based upon an act committed before the date of qualification of the accused as a member of this Faculty. Furthermore, no member shall be entitled to the privileges of defense by the Council whose dues to the Faculty are not paid in advance as elsewhere provided in the Constitution and By-Laws, and such defense shall be granted only to members residing in Maryland and not to non-resident, or associate, or affiliated members. New members of component societies elected after January 31, whose dues are paid on or before the day of their election, will be entitled to Physicians' Defense, but only for acts committed after their election.

Amendment:

Delete: ARE NOT PAID IN ADVANCE AS ELSEWHERE PROVIDED IN THE CONSTITUTION AND BY-LAWS,

Delete: OR AFFILIATE

Amended reading of

Section 6. (c)

The Council shall not undertake the defense of any suit based upon an act committed before the date of qualification of the accused as a member of this Faculty. Furthermore, no member shall be entitled to the privileges of defense by the Council whose dues to the Faculty HAVE NOT BEEN PAID IN ADVANCE PRIOR TO JANUARY 31st AS ELSEWHERE PROVIDED IN THE CONSTITUTION, FOR THE YEAR IN WHICH THE MALPRACTICE IS ALLEGED TO HAVE OCCURRED AND EACH SUBSEQUENT YEAR TO AND INCLUDING THE YEAR WHEN THE REQUEST IS MADE, and such defense shall be granted only to members residing in Maryland and not to non-resident or associate members. New members of component societies elected after January 31, whose dues are paid on or before the date of their election, will be entitled to Physicians' Defense, but only for acts committed after their election.

Explanation:

Chapter VII

Section 6

(c)

Due to problems presented in the case of malpractice suits, and the fact that the Attorney for the Faculty, Mr. G. C. A. Anderson, felt that the wording in our Constitution and By-Laws is not clear, this amendment to the By-Laws has been suggested.

The following has been pointed out by Mr. Anderson. The purpose of this amendment is to remove any ambiguity with reference to the payment of dues and right of Defense.

"the important year is not the year of the alleged malpractice but the year in which the claim is made."

"a Faculty member might be charged with an alleged malpractice which occurred during the year in which he paid his dues on or before January 31st, but no claim be made upon him until the next year, when the member has not paid his dues on or before January 31st as required by the By-Laws. Such a member would *not* be entitled to a defense.

"It is logical that the year in which the claim is made be the decisive year, since it is of the utmost importance that when the defense is undertaken, the physician be a member of the Faculty. If the year in which the claim is made is not the decisive year, it would be possible for an alleged malpractice to occur in one year and the claim be made in another year when the doctor involved might no longer be a member of the Faculty. Under such circumstances, the Faculty would be called upon to defend a non-Faculty member."

It is certainly just as important that Faculty dues should be paid regularly and in time as it is to meet health and accident and life insurance premiums regularly and on time if protection benefits are to be expected.

CHAPTER VIII—Standing Committees

Section 1.

The standing committees which are to be elected by the House of Delegates, are as follows:

Committee on Scientific Work and Arrangements, Library Committee, Finney Fund Committee.

The standing committees, which are to be named by the President are:

A Nominating Committee, Resolutions Committee.

Standing Committees, organized as hereinafter provided are:

House Committee, Finance Committee, Professional Conduct Committee, Resolutions Committee.

Amended to read:

The standing committees which are to be elected by the House of Delegates, are as follows:

Committee on Scientific Work and Arrangements, Library Committee, Finney Fund Committee.

The standing committees, which are to be named by the President, ORGANIZED AS HEREINAFTER PROVIDED, ARE THE

Nominating Committee, Resolutions Committee, COMMITTEE ON CONSTITUTION AND BY-LAWS.

Standing Committees, organized as hereinafter provided are:

House Committee, Finance Committee, Professional Conduct Committee.

Explanation: The Council recommended that provision be made in the By-Laws for the Committee on Constitution and By-Laws.

CHAPTER VIII

Section 8. *Professional Conduct Committee.* This Committee shall consist of the five immediate Past Presidents of the

Medical and Chirurgical Faculty with the Senior Past President as Chairman of the Committee. The function of this Committee will be to hear legitimate grievances against members of the Society, examine the facts of the grievances and make recommendations as to their disposition to the Council of the Faculty.

Section 9. *Resolutions Committee.* The Resolutions Committee shall consist of five members to be appointed annually by the President of the Medical and Chirurgical Faculty, who shall also designate the Chairman of the Resolutions Committee. This Committee shall be chosen from the House of Delegates, and shall be appointed at least 30 days before the Annual Meeting of the House of Delegates.

Amendment:

Section 8.

Insert: after "Medical and Chirurgical Faculty" AND THE CHAIRMAN OF THE COUNCIL

Explanation: Section 8.

This was inadvertently omitted when this Section of the Constitution and By-Laws was written.

Amendment:

SECTION 10. *CONSTITUTION AND BY-LAWS COMMITTEE.* THE COMMITTEE ON CONSTITUTION AND BY-LAWS SHALL CONSIST OF FOUR MEMBERS TO BE APPOINTED BY THE PRESIDENT OF THE MEDICAL AND CHIRURGICAL FACULTY WHO SHALL ALSO DESIGNATE THE CHAIRMAN OF THIS COMMITTEE. IT SHALL BE THE DUTY OF THIS COMMITTEE TO REVIEW ALL REQUESTED CHANGES IN THE CONSTITUTION AND BY-LAWS AND MAKE RECOMMENDATIONS AS TO AMENDMENTS IN THE CONSTITUTION AND BY-LAWS TO THE COUNCIL AND HOUSE OF DELEGATES, BUT FINAL ACTION MAY BE TAKEN ON SUCH AMENDMENTS AS ELSEWHERE PROVIDED IN THE CONSTITUTION AND BY-LAWS.

Explanation: Section 10.

This amendment was recommended by the Council as it was the feeling that in these changing times, the Committee on Constitution and By-Laws should be provided for in this manner.

CHAPTER IX—Component Societies

Section 9.—*Assessments.*—The Secretary of each component society shall forward its per capita assessment, together with its roster of officers and members, list of delegates, and list of non-affiliated physicians of the county to the Secretary of this Faculty each year ten days before the Annual Session. Active members who shall have paid their dues on or before January 31st of any year shall be entitled to defense against alleged malpractice suits, as provided for in Chapter 7, Section 6, of the By-Laws, but only for acts alleged to have been committed during a fiscal year paid for in advance. The fiscal year of the Faculty shall be coincident with the calendar year. Members of component societies who have not paid their dues ten days prior to the Annual Meeting, shall be suspended from the Faculty without further action on the part of the Faculty, but may be reinstated on the payment of all indebtedness to the Faculty, but such reinstatement cannot be made until after the Annual Meeting. Such members, who are in arrears for over one year, shall again come before the Board of Censors of the component society to which they belonged, before being reinstated. Members so suspended shall not have any privileges of the Faculty until all indebtedness to the Faculty shall have been paid.

Amend to read:

The Secretary of each component society shall forward its per capita assessment, together with its roster of officers and members, list of delegates, and list of non-affiliated physicians of the county to the Secretary of this Faculty each year ten days before the Annual Session. Active members who shall have paid their dues IN ADVANCE on or before January 31st FOR THE YEAR IN WHICH THE MALPRACTICE IS ALLEGED TO HAVE OCCURRED AND EACH SUBSEQUENT YEAR TO AND INCLUDING THE YEAR WHEN THE REQUEST IS MADE AS PROVIDED ELSEWHERE IN THIS CONSTITUTION, Chapter 7, Section 6 of the By-Laws, SHALL BE ENTITLED TO DEFENSE AGAINST ALLEGED MALPRACTICE SUITS, but only for acts alleged to have been committed during a fiscal year paid for in advance.

(Remainder of Section 9 is unchanged.)

Explanation:

Same as explanation to Chapter VII, Section 6 (c) on Pages 6 and 7.

This following amendment was not mailed to the members

BY-LAWS

(Amendment appears in CAPITAL LETTERS)

CHAPTER I—Membership

Section 4. *Emeritus Members.* An Active Member in good standing may, on the recommendation of the Council, and a majority vote of the House of Delegates, be made an Emeritus Member, enjoying without payment of dues all the privileges of the Faculty, except of holding office and of the provisions of Physicians' Defense.

Amendments:

Delete: (and of the provisions of Physicians' Defense)

Insert: HE SHALL NOT BE ELIGIBLE FOR PHYSICIANS' DEFENSE FOR ALLEGED MALPRACTICE OCCURRING AFTER BECOMING AN EMERITUS MEMBER.

Explanation: Mr. G. C. A. Anderson, attorney for the Medical and Chirurgical Faculty, has recommended this amendment to conform with the change in reference to Physicians' Defense.

The Committee wishes to thank Mr. Kirkman and the Office Staff for their assistance in compiling this report.

Respectfully submitted,
A. Austin Pearre, *Chairman*
E. Cowles Andrus
Donald Hooker
W. Houston Toulson
Committee on the Constitution and By-Laws

EUGENE FAUNTLEROY CORDELL FUND COMMITTEE

Mr. President and Members of the House of Delegates:

The one beneficiary, a granddaughter of a physician, is hospitalized. From the Fund, at the request of the hospital, some clothing which was needed by the patient, has been purchased. The income for the year was $323.56, and the cash on hand as of December 31, 1952, is $4,871.30.

Respectfully submitted,
T. Nelson Carey, M.D., *Chairman*
James K. Gray, M.D.
William L. Howard, M.D.
Frank F. Lusby, M.D.
George Allen Moulton, Jr., M.D.

DIABETIC DETECTION COMMITTEE

Mr. President and Members of the House of Delegates:

The Committee undertook a new attack on the problem of Diabetes Detection during the year 1952. Efforts were directed entirely along educational lines such as radio and television programs for the layman. At the same time, but with special emphasis during Diabetes Week in November, efforts were made to get the general population to consult a physician of choice to determine whether or not they had diabetes. No real estimate can ever be very accurately made of the number of people who were aroused by this appeal.

The real objective of this Committee is to keep the profession alert to the possibility of diabetes. This, no doubt, is best accomplished by concerted effort during the week designated nationally as Diabetes Week. If all physicians during this week would conduct a urine screening test free of charge for diabetes, a great service would be accomplished. There are probably about 1,000,000 people in the United States who have diabetes and are unaware of it. It is the duty of the medical profession to find these cases.

Respectfully submitted,
J. Sheldon Eastland, M.D., *Chairman*
E. Irving Baumgartner, M.D.
T. Nelson Carey, M.D.
James D. Carr, M.D.
J. Wilfrid Davis, M.D.
Perry Futterman, M.D.
Frank J. Geraghty, M.D.
David J. Gilmore, M.D.
Lewis P. Gundry, M.D.
J. Roy Guyther, M.D.
John H. Hornbaker, M.D.
Benjamin F. Jones, M.D.
Charles F. O'Donnell, M.D.
Harold Plummer, M.D.
J. Emmett Queen, M.D.
George G. Schlesinger, M.D.
Frank M. Shipley, M.D.
A. A. Silver, M.D.
Benedict Skitarelic, M.D.
Lester A. Wall, Jr., M.D.

GERIATRICS COMMITTEE

Mr. President and Members of the House of Delegates:

I wish to submit a brief report on the activities of the Committee on Geriatrics of the Medical and Chirurgical Faculty of the State of Maryland.

Our Committee did not begin to function until the early Fall and even then, it found itself handicapped because of the distance some of the members had to travel in order to come to a meeting. Another handicap which may or may not be remedied for the coming year, is the lack of a designated budget for the Committee.

It was thought that because at least two of the members of the Medical and Chirurgical Faculty of the Committee on Geriatrics were likewise members of a similar Committee of the Baltimore City Medical Society and because the Chairman of the Medical and Chirurgical Faculty Committee was also Chairman of the Baltimore Medical Society Committee, that matters may be facilitated to have joint meetings and to work out joint activities.

To date, your Committee wishes to report that on December 9, 1952, a panel discussion on the problems of the aging and the aged has been held at the Central Pratt Library in the City of Baltimore jointly with the Baltimore City Medical Society Committee. The participants were: Judge J. S. T. Waxter, Director of the Department of Public Welfare of the city of Baltimore, Dr. Louis Krause, Professor of Medicine at the University of Maryland, Joseph Folkoff, Executive Director of Levindale which is the Hebrew Home of the Aged and the Infirm.

At the same time, the Library granted us one of their windows for the display of material bearing upon the activities and progress of Geriatrics in this county.

Jointly with the Baltimore City Medical Society's Committee, plans have been completed for two projects:

1) A Bookmobile arrangement to display a substantial collection of books, journals, and monograms at various hospitals in the city of Baltimore and the counties throughout the State.
2) Clinical rounds on Geriatrics at the Home for Incurables of Baltimore, at Levindale which is the Hebrew Home for the aged and the infirm and at City hospitals.

Later on, these clinics will be extended to points in the counties throughout the State.

Respectfully submitted,
Herman Seidel, M.D., *Chairman*
Thurston Harrison, M.D.
Louis Krause, M.D.
A. Austin Pearre, M.D.
Winthrop M. Phelps, M.D.
Howard K. Rathbun, M.D.

COMMITTEE ON INDUSTRIAL HEALTH

Mr. President and Members of the House of Delegates:

The Committee on Industrial Health has not been as active during the past year as I would have liked. The chief aims of this committee have been (1), to stimulate interest of management and the physicians of the State in Industrial Health and (2), to supply to interested parties information concerning industrial health. Unfortunately we have not been very successful in these respects. However, due to the excellent departments in Industrial Hygiene maintained by the City and State Departments of Health, no real difficulty has occurred. Moreover many of the insurance companies maintain adequate departments of safety engineering and it is quite likely that management has availed itself of these facilities.

Respectfully submitted,
Nathan B. Herman, M.D., *Chairman*
Robert Van Lieu Campbell, M.D.
Robert F. Chenowith, M.D.
Walter E. Fleischer, M.D.
William L. Garlick, M.D.
Hugh C. Gill, M.D.
W. R. Hodges, Jr., M.D.
John V. Hopkins, M.D.
Robert H. Riley, M.D.
Benjamin H. Ruthledge, M.D.
Leroy W. Saunders, M.D.
W. Kennedy Waller, M.D.
William F. Williams, M.D.
Huntington Williams, M.D.

LEGISLATIVE COMMITTEE

Mr. President and Members of the House of Delegates:

In the 1953 session of the General Assembly of Maryland, a total of approximately 1500 Bills were introduced and about 1480 were closely inspected for medical implication.

In past years, this Society has been fortunate in having the services of an experienced Legislative Agent in the person of Mr. J. Davis Donovan, but since he was not available to us this year, and since we did not learn of this until after the start of the session, this work fell on our Director, Mr. Kirkman. Much of the legislation was of the type that did not require direct action, but did require observation. Since Mr. Kirkman has already a full-time job in his regular work as Director and, since the work at the Legislature is of utmost importance, it is highly important that the Society begin at once to look for the services of a Legislative Agent for the next full session.

The following Bills required our direct action at this session:

(1) *Senate Bill No. 41*

This Bill defines the persons who may give permission for autopsies. Such definition had never been legally made before. We were in favor of this Bill and it was passed without opposition.

(2) *Senate Bill No. 137*

This Bill would license Naturopaths to practice medicine. A hearing was conducted before the Judicial Proceedings Committee and representatives of the Society and the Medical Schools appeared with us in opposition to the Bill. Although it looked for a while that the Committee might be sympathetic toward the Bill, the Bill received an unfavorable and hold report and so died in Committee.

Because it was the feeling of some of the Legislators that the Naturopaths should have regulatory legislation in view of the fact that some were already practicing in Maryland, the Committee recommends that the Society go on record as approving taking steps to ascertain whether or not they are in fact practicing medicine and, if so, the matter be referred to the Board of Medical Examiners for action.

(3) *Senate Bill No. 171*

This Bill would remove from the present law the restriction on Optometrists prescribing glasses for near-sighted children. This Bill passed the Senate over our opposition and got a favorable report from the House Judiciary Committee, but failed to pass for lack of a Constitutional majority. If this subject comes up again before the Legislature, more vigorous steps must be taken to oppose it by the physicians who would be directly effected.

(4) *Senate Bill No. 180*

This Bill would change the Constitution of the Board of Examiners of the Physical Therapists from the present Board of five physicians to a Board composed of three physicians and three physical therapists. Because of the split in the organizations of the Physical Therapists, this Bill was opposed by the Medical Society. This received a favorable report and passed the Senate but following a hearing before the House Judiciary Committee, an unfavorable and hold report was made so this Bill died in Committee in the House.

(5) *Senate Bill No. 185*

This Bill raised the educational requirements for the practice of Chiropractic in Maryland. Since this Bill did not involve medical practice in any way, the Society did not oppose it and it passed both Houses.

(6) *House Bill No. 312*

This Bill defined more specifically the practice of Chiropody, but did not essentially change the practice of Chiropody. This Bill was submitted to the Society prior to its introduction and the Faculty decided not to oppose it. The Bill passed both Houses.

(7) *House Bill No. 898*

This Bill would abolish the Medical Board of the State Industrial Accident Commission, and have such cases as it formerly decided heard before the Commission, the same as other accident cases. This Bill was opposed by the Society but was never reported out of Committee because of its late introduction.

The Committee wishes to express its deep gratitude to Mr. Kirkman for his efficient work with the Legislative Committee.

The recommendations stated above concerning the employment of a Legislative Agent for the long session of the Legislature is repeated to emphasize this.

Respectfully submitted,
Karl F. Mech, M.D., *Chairman*
Frederic V. Beitler, M.D.
Thomas A. Christensen, M.D.
George O. Eaton, M.D.
Raymond F. Helfrich, M.D.
Norbert C. Nitsch, M.D.
Willard S. Parsons, M.D.
Daniel J. Pessagno, M.D.
J. G. F. Smith, M.D.
James E. Stoner, Jr., M.D.
George E. Urban, M.D.
I. M. Zimmerman, M.D. (deceased)

MATERNAL AND CHILD WELFARE COMMITTEE

Mr. President and Members of the House of Delegates:

This report is again in two parts, the first dealing with maternal health and the second with the welfare of the newborn. During the year Dr. D. C. Wharton Smith felt compelled to resign, both as Vice-Chairman in charge of the pediatric section and from the committee itself. It was with real regret that the chairman felt compelled to accept this resignation and to forward it to the President of the Faculty. Dr. Smith has served long and faithfully on this committee and every man, woman and child in the state owes him a vote of thanks for his guidance and his untiring efforts. Upon recommendation, Dr. J. Edmund Bradley was appointed Vice-chairman to succeed Dr. Smith.

Your committee reports that during the year there were 27 maternal deaths, by residence, in the counties of Maryland exclusive of Baltimore City. Of these 8 were white and 19 negro. The rates for these 2 classifications per 1000 live births is 0.6 and 1.8 respectively. Again we find the rate among negro mothers many times higher than among white. The combined rate is 0.8 per 1000 live births, a rate which compares most favorably with most of the states.

In addition to these 27 *maternal* deaths, there were 7 deaths from non-maternal causes but associated with pregnancy. For example, in 3 of these 7 the cause of death was stated to be rupture of a cerebral aneurysm. Therefore the total of deaths associated with pregnancy was 34 or a rate of 1.0 per thousand live births.

Of the 27 maternal deaths only 20 could be reviewed by the committee; in the remainder the survey form was not returned. Of the 20 which were reviewed, 14 or 70% were considered preventable, or deaths which should not have occurred. In some instances the physician was considered to be at fault, in others it was the patient and in a few a combination of physician and patient.

Hemorrhage occupies first place as the cause of death, there being 14 cases from this complication. Second we find toxemia with 3 deaths only and third infection, which was the cause only twice during the year. The remaining 10 were classed under the general heading miscellaneous. In looking at this miscellaneous group it is found that there are 5 deaths ascribed to embolism. Unfortunately all of these were not substantiated by autopsy.

In looking over maternal deaths from previous years it was found that for the past 7 years hemorrhage has consistently been responsible for between 39% and 50% of all maternal deaths. Your committee has annually made a plea for more blood for replacement in the counties and we are happy to report that despite the large percentage of deaths from hemorrhage in 1952, this was the first year in which there was no death considered preventable on the basis of inadequate blood replacement. It would appear that the majority of the hospitals in the counties now have reasonably adequate facilities for this form of therapy.

As mentioned before, in 7 of the 27 maternal deaths during the year the attending physician failed to complete and return the survey form which is necessary to evaluate the death. While this seems at first glance to be a high percentage of failure, the actual number of physicians involved is small, only 3 to be exact. We regret to report that most of these 3 are chronic offenders in this regard.

On the other hand the committee wishes to express its thanks to those who have cooperated so well and have rendered such complete reports. It is most gratifying to report that of the 27 deaths, over 54% were submitted to autopsy. In 1948 the autopsy percentage was only 14.7 and it has increased each year since that time.

Your committee requests assistance from the physicians of the state in one respect. The committee is anxious to review all deaths of women who are or who recently have been pregnant, even though the death is evidently non-maternal. Since our only source of information is the death certificate it is urged that the physicians be requested to note on this document the fact that the patient was pregnant or had recently delivered.

PEDIATRIC SECTION OF THE COMMITTEE ON MATERNAL AND CHILD WELFARE

Since prematurity is still the major cause of infant mortality, the Pediatric Section continued to study premature infant deaths during 1952. Preliminary figures for 1952 show a total of 1,687 infant deaths in the State with 707 premature infant deaths. Thus, approximately, 41.9% of infant deaths were due to prematurity. 997 infants died in the county during 1952, and of these, 406 were premature infant deaths. 44 case reports were studied. The main causes of death, exclusive of extreme immaturity, were infection and aspiration of vomitus (often due to improper feeding). The quality of care being given to premature infants is generally excellent and has shown marked improvement over the years. The autopsy percentage was excellent, 14 out of 44 cases being autopsied.

The infant mortality rate in 1952 was 29.4%. In 1951, it was 28.9% and in 1950, 28.2%. There appears to be a slight but steady rise which your committee cannot explain. The second highest cause of mortality is congenital malformation (250) and the third is injury at birth (108). There continues to be a marked difference in death rate between white (25.1) and colored (45.6). A large factor in this is probably the lack of hospital facilities for colored obstetrical and pediatric patients.

The committee considers that an important part of its work is educational. Under its auspices, the brochure "Suggested Guide for the Care of Premature Infants" was revised in 1952 and distributed to the physicians of the State. The committee served as advisers to the Maryland State Department of Health in drawing up "Regulations for Newborn Nurseries, Full Term and Premature," and "Appendix to Regulations for Newborn Nurseries, Full Term and Premature." These were completed in November 1952 and are incorporated in Regulations for Hospitals under the Maryland Licensing Law.

The Premature Infant Study by the Division of Maternal and Child Health of the School of Hygiene and Public Health of the Johns Hopkins University was completed on December 31, 1952. Over 4,000 premature infants have been included. The cooperation of the Hospitals, physicians and Health Department has been excellent. It was reported by the director of the study that they might continue the study of premature infants born at home for an additional year. In regards to this proposed additional phase of the study, the following resolution was passed unanimously, "The Pediatric Section of the Committee on Maternal and Child Health of the Medical and Chirurgical Faculty of Maryland believes that the study of premature infants under the auspices of the Johns Hopkins School of Hygiene and Public Health is extremely important in bringing out information of interest to this Section in discharging its duties given it by the Medical and Chirurgical Faculty. The Pediatric Section urges the physicians to continue their fine cooperation in this study."

The Pediatric Section continues to serve as the Maryland Committee on Fetus and Newborn of the American Academy of Pediatrics. Early in the year, a preliminary draft of the pamphlet "Regulations for Standards for Newborn Nurseries, Full Term and Premature" was submitted to the Maryland Committee for review by the Academy. A number of changes suggested by our Section were incorporated in the final form which was completed in late 1952.

The question regarding the rational use of the Bloxsom airlock has been raised repeatedly by committee members. It is the feeling of the committee that there is no justification of the use of the airlock in those infants who are making good respiratory efforts.

It was with regret that the members of the Pediatric Section received word of the resignation of Dr. D. C. Wharton Smith as its Chairman. The Section is indebted to him for his capable and inspiring leadership throughout the six years since its creation. During this period, the Committee's efforts were directed toward improving the care of premature infants, and it is felt that the quality of care given has increased considerably. The Section wishes to extend its congratulations to the physicians in the counties. It is now felt that the Committee can enlarge the scope of its study to include other causes of neonatal mortality.

Respectfully submitted,
Louis H. Douglass, M.D., *Chairman*
J. Edmund Bradley, M.D.
George W. Anderson, M.D.
J. Tyler Baker, M.D.
John McF. Bergland, M.D.
Annie M. Bestebreuertje, M.D.
Harry D. Bowman, M.D.
Thomas A. Christensen, M.D.
Stuart Christhilf, Jr., M.D.
George H. Davis, M.D.
Darius McC. Dixon, M.D.
Nicholson J. Eastman, M.D.
H. W. Eliason, M.D.
A. H. Finkelstein, M.D.
S. Butler Grimes, M.D.
Wilson Grubb, M.D.
Russell L. Guest, M.D.
I. R. Hanson, M.D.
Virginia G. Harris, M.D.
Paul Harper, M.D.
John S. Haught, M.D.
W. Royce Hodges, Jr., M.D.
William K. Mansfield, M.D.
William C. Morgan, M.D.
J. Morris Reese, M.D.
John E. Savage, M.D.
Alexander J. Schaffer, M.D.
Francis F. Schwentker, M.D.
William C. Stifler, Jr., M.D.
Byron D. White, M.D.
John Whitridge, Jr., M.D.

COMMITTEE ON MEDICAL RESEARCH

Negative.

R. Walter Graham, Jr., M.D., *Chairman;* Drs. A. Blalock, A. M. Chesney, C. R. Edwards, W. M. Firor, W. Fort, A. E. Goldstein, J. H. Hornbaker, D. I. Macht, L. A. Rodemaker, W. A. Van Ormer, T. E. Woodward, G. H. Yeager, H. B. Wylie, *ex officio*.

JOINT COMMITTEE WITH THE BAR ASSOCIATIONS ON MEDICO-LEGAL PROBLEMS

Mr. President and Members of the House of Delegates:

This Committee, which is comprised of members of the Medical and Chirurgical Faculty and the Bar Associations, has continued its activities since our last report, April 1952.

Two of the subcommittees have met on numerous occasions.

The Subcommittee on Court Procedure met to discuss their project which is a plan for a list of expert witnesses to be made available from which the Court may select physicians.

The Subcommittee on Symposia Management have arranged the following meetings to which were invited the legal and medical professions and the public, and these presentations have been the result of much preliminary work and many conferences:

1. Euthanasia. March 28, 1952. Participants: Mr. John S. Stanley, Dr. George Boas, Mr. Charles E. Orth, Jr., and Dr. Louis Krause.
2. Trauma and Its Relation to Disease. October 24, 1952. Participants: Mr. Paul F. Due, Dr. Russell F. Fisher, Mr. Joseph L. Lilienthal, Jr. and Dr. Eugene Meyer, III.
3. Medical and Legal Aspects of the Adoption Law. February 6, 1953. Participants: Judge Herman M.

Moser, Dr. Georgeanna Seegar Jones, Mr. Thomas J. S. Waxter, and Mr. G. C. A. Anderson.

It has been the feeling of the Committee that these meetings have been worthwhile as Osler Hall on each occasion has been comfortably filled. The objective of the Subcommittee on Symposia Management has been to select subjects for discussion that are of common interest to the two professions. The papers presented have been published in the Maryland State Medical Journal and therefore are available to all the members.

The efforts, time and work of the various members of the Committee is greatly appreciated since it must be a sacrifice in the ordinary fully occupied day of everyone.

Respectfully submitted,
LOUIS KRAUSE, M.D., *Chairman*
CONRAD ACTON, M.D.
LEO BRADY, M.D.
RUSSELL S. FISHER, M.D.
MANFRED S. GUTTMACHER, M.D.
CHARLES A. REIFSCHNEIDER, M.D.
R. CARMICHAEL TILGHMAN, M.D.
I. RIDGEWAY TRIMBLE, M.D.
HENRY F. ULLRICH, M.D.
THOMAS CONRAD WOLFF, M.D.

MEMOIR COMMITTEE

Mr. President and Members of the Medical and Chirurgical Faculty:

The Memoir Committee has the annual honor to recall to the minds of the Society those members who have gone before us into their well earned rest and reward. The past year has marked grievous losses.

Gynecology has said farewell to the last of The Hopkins Big Four; Surgery has suffered loss in the Industrial and in the Plastic field; Teachers and trusted consultants have left us in Otorhinolaryngology, and Anesthesiology has lost a sure hand; a veteran voice is not heard in the State Department of Health and many familiar figures, long faithful supporters of the work of the Society in quiet ways are seen no longer.

The continuance into this Atomic Age of our quaint title of the Medical and Chirurgical Faculty is enough to show that we are mindful and not ungrateful for the mold of the past in which have germinated the seeds of the future, which it is our brief privilege to cultivate and bring a step farther toward fruition, in this Garden no longer Eden and not yet Paradise. We will recognize among these names, some who were our teachers, who put tools in our hands, some to whom we looked for leading in our work, some who hoed a long row ahead of us and some, alas, whose work was snatched too quickly from their hands for much of fame or satisfaction.

Let us think for a moment fondly of them and of their families, whose notes in our file acknowledge the messages of condolence sent, thru the year, in your name, by your faithful and watchful staff. These brief and pathetic notes give ample testimony that in an intimate and special way these losses can never be replaced—without whom the world is a poor place indeed, but for the warmth and light their memory sheds on the remaining days.

And, if time and Creative energy have not sufficed to bring much substance to the dreams of Youth or Age, let us have faith to believe that their best efforts and ours are never lost, but are part of an organic and continuing purpose, whose power gives meaning and blessing to each life of service we here commemorate.

Baltimore City

Ballard, Edwin Kemp	October 14, 1952
Bampfield, F. J.	September 20, 1952
Billups, Gaius W.	December 26, 1952
Cannon, Burdelle S.	June 11, 1952
Carman, R. Perry	February 3, 1952
Cullen, Thomas S.	March 4, 1953
Fine, Morris A.	June 4, 1952
Fleck, H. K.	January 3, 1952
Franklin, David	May 1, 1952
Hanrahan, Edward M.	September 30, 1952
Holly, Julius David	October 9, 1952
Janney, Francis W.	February 1, 1953
Keown, Thomas W.	June 28, 1952
Locher, Roy W.	January 3, 1953
Looper, Edward A.	January 14, 1953
Michelson, Rudolph A.	August 20, 1952
Moncure, Turner A.	April 23, 1952
Rohrer, Caleb W. G	July 23, 1952
Rytina, Anthony G.	September 13, 1952
Stevens, Thomas F. A.	July 26, 1952
Weisman, Samuel	September 25, 1952

Allegany-Garrett County

Hawkins, A. H., *Cumberland*	June 9, 1952
Matthai, Jacob H., *Cumberland*	September 29, 1952
Taylor, E. Don, *Lonaconing*	February 10, 1953

Anne Arundel County

Claffy, John M., *Annapolis*	July 26, 1952

Baltimore County

Glantz, Frank A., *Baltimore*	August 31, 1952
Green, John S., Jr., *Towson*	May 26, 1952
Gundry, Alfred T., *Catonsville*	June 6, 1952
McCormick, G. Carville, *Florida*	April 21, 1952

Caroline County

Wright, James F., *Denton*	June 24, 1952

Dorchester County

Brown, Hugh, *Cambridge*	February 11, 1952

Harford County

Van Bibber, Armfield F., *Bel Air*	January 16, 1953

Prince George's County

Norton, Wiliam H., *Mt. Rainier*	February 28, 1952

Washington County

Yeager, W. H., *Hagerstown*	July 19, 1952
Zimmerman, I. M., *Williamsport*	March 17, 1953

Nonresident

Corbett, William W., *California*........February 25, 1953
Holmes, James B., *Florida*.............March 5, 1952

Respectfully submitted,
A. S. Chalfant, M.D., *Chairman, Baltimore*
Harry D. Bowman, M.D., *Hagerstown*
Lynn H. Brumback, M.D., *Hagerstown*
F. A. Camalier, M.D., *Leonardtown*
W. N. Palmer, M.D., *Easton*

MENTAL HYGIENE COMMITTEE

Negative.

Harry M. Murdock, M.D., *Chairman;* Drs. D. M. Bullard, R. E. Gardner, K. B. Jones, W. S. Muncie, H. W. Newell, I. J. Spear, R. P. Truitt.

COMMITTEE ON NATIONAL EMERGENCY MEDICAL SERVICE

Mr. President and Members of the House of Delegates:

Program for Medical Civil Defense activities for the coming year:

1. Prompt assignment of all professional volunteers to appropriate Civil Defense units, to be followed by a campaign to include all members of local and State professional societies.
2. Responsibility for enrollment of volunteers to be placed on individual units, with the objective of bringing all units to operational status. Units to continue their own training.
3. The Chief of Medical Services to convene meetings of Medical Directors in each of the metropolitan areas, to coordinate mutual aid.
4. After casualty clearing stations have received their equipment, to hold a series of demonstrations and rehearsals designed to familiarize them with their duties and to acquaint communities and other Civil Defense services with the capabilities and limitations of the stations.
5. As assignments are made to Hospitals and Community Clinics, their staffs to hold conferences and draw up plans for their individual facilities.
6. To complete and implement a State Blood Program.

Respectfully submitted,
Robert H. Riley, M.D., *Chairman*
J. Albert Chatard, M.D.
Alan M. Chesney, M.D.
C. Reid Edwards, M.D.
Charles W. Maxson, M.D.
Walter D. Wise, M.D.
George H. Yeager, M.D.
Mr. George Buck
Mr. Walter N. Kirkman

NEW BUILDING COMMITTEE

Mr. President and Members of the House of Delegates:

The name of the Committee has been changed from the Sesquicentennial Committee to the New Building Committee. Dr. Goldstein's report, which follows, covers the present activities in relation to the future annex of the Medical and Chirurgical Faculty.

Respectfully submitted,
C. Reid Edwards, M.D., *General Chairman*
Albert E. Goldstein, M.D., *Chairman, Finance Committee*
John W. Parsons, M.D., *Treasurer, Finance Committee*
R. Walter Graham, Jr., M.D., *Chairman, Building Plans*
Harry C. Hull, M.D.
I. R. Trimble, M.D.

SUBCOMMITTEE ON FINANCE, NEW BUILDING COMMITTEE

Mr. President and Members of the House of Delegates:

In reporting on the Building Fund, the committee is at a standstill at the present time. At a recent meeting of the committee it was unanimously suggested that since a large percentage of physicians in the city have failed to recognize their obligation to the society, that it might be better to assess each physician a small sum of money, say fifteen dollars, over a period of ten years. This assessment should include the county as well as the city physicians. This was presented before the Council who recommended that we continue our campaign as before, until it is presented before the entire House of Delegates.

While the Building Fund Committee does not object to continue the campaign as it has in the past, we look upon it as more equitable if all members will participate. The appeal we make is that something drastic is necessary since the conditions in the library are continually becoming worse rather than better. Unless some effort is made by the members, we stand to lose a great deal.

Up to the present time 571 physicians in the city have pledged in varying amounts and 54 physicians in the counties have pledged an amount of $6,395.00, making a total number of 625 physicians in the state pledging $73,500.00 of which $64,193.81 has been paid and deposited in the bank.

The Committee shall continue its efforts as it has been and we hope that each and every physician will take a personal pride in the campaign and contribute his share or whatever he feels able to do.

Respectfully submitted,
Albert E. Goldstein, M.D., *Chairman*

W. B. Allan, M.D.
J. G. Arnold, Jr., M.D.
J. A. Askin, M.D.
W. A. Baetjer, M.D.
A. Bernstein, M.D.
C. B. Brack, M.D.
L. Brady, M.D.
O. C. Brantigan, M.D.
H. A. Briele, M.D.
W. H. Brown, M.D.
E. N. Broyles, M.D.
F. E. Chatard, IV, M.D.
B. C. Compton, M.D.
L. C. Dobihal, M.D.
L. H. Douglass, M.D.
M. Edwards, M.D.
W. R. Ferguson, M.D.
J. M. T. Finney, Jr., M.D.
W. Fort, M.D.
F. J. Geraghty, M.D.
T. K. Galvin, M.D.
M. E. Gann, M.D.
R. W. Garis, M.D.
L. P. Gundry, M.D.

L. P. Hamburger, Sr., M.D.
H. H. Hopkins, M.D.
H. C. Hall, M.D.
J. M. Hundley, Jr., M.D.
P. C. Jett, M.D.
H. J. Jewett, M.D.
M. P. Johnson, M.D.
J. T. King, M.D.
E. P. Knotts, M.D.
L. A. Kochman, M.D.
A. R. Koontz, M.D.
E. F. Lewison, M.D.
E. T. Lisansky, M.D.
H. I. Maginnis, M.D.
W. K. Mansfield, M.D.
E. E. Mayer, M.D.
K. F. Mech, M.D.
W. B. Moyers, M.D.
W. R. McKenzie, M.D.
S. McLanahan, M.D.
E. Novak, M.D.
F. J. Otenasek, M.D.
D. J. Pessagno, M.D.
E. L. Richards, M.D.
H. M. Robinson, Jr., M.D.
F. B. Smith, M.D.
H. C. Smith, M.D.
R. W. TeLinde, M.D.
E. P. Thomas, M.D.
R. K. Thompson, M.D.
W. H. Toulson, M.D.
I. R. Trimble, M.D.
H. F. Ullrich, M.D.
G. E. Ward, M.D.
L. R. Wharton, M.D.
W. L. Winkenwerder, M.D.
W. D. Wise, M.D.
H. Wollenweber, M.D.
A. H. Wood, M.D.
J. D. Woodruff, M.D.
A. C. Woods, M.D.
I. S. Zinberg, M.D.

SUBCOMMITTEE ON BUILDING PLANS, NEW BUILDING COMMITTEE

Negative.

R. Walter Graham, Jr., M.D., *Chairman*

COMMITTEE FOR THE STUDY OF PELVIC CANCER

Mr. President and Members of the House of Delegates:

Fifteen hospitals in Baltimore City are now cooperating with the Committee for the Study of Pelvic Cancer in its review of pelvic cancer cases. Four hospitals, not previously participating, have joined in the study this year—Franklin Square, Maryland General, Mercy and St. Joseph's.

As of March 15th, 1953, three hundred and fifty-four cases have been reviewed and classified according to the delay period between the time of onset of symptoms and the time of correct diagnosis and adequate treatment. We have considered elapsed time of more than one month as delay. The cases have been classified as follows:

No delay	123	34.7%	
Patient delay	148	41.8%	
Physician delay	34	9.6%	19.8%
Patient and physician delay	15	4.2%	
Institutional delay	12	3.4%	
Physician and institutional delay	2	.6%	
Patient and institutional delay	6	1.7%	
Patient, physician and institutional delay	1	.3%	
Asymptomatic detected cases	13	3.7%	

A meeting of the Committee is held on the third Thursday of each month. At this time selected cases are presented for discussion. All doctors concerned in the treatment of the cases are invited to attend the meetings, and their response has been good. The general attendance has been disappointing. We feel the meetings are worthwhile and should be of interest to all gynecologists, and particularly to the resident staff of the participating hospitals.

Respectfully submitted,
Richard W. TeLinde, M.D., *Chairman*
J. Mason Hundley, Jr., M.D.
Beverley C. Compton, M.D.
C. Bernard Brack, M.D.
Robert N. Cooley, M.D.
Charles N. Davidson, M.D.
Everett S. Diggs, M.D.
Howard W. Jones, Jr., M.D.
Theodore Kardash, M.D.
Emil Novak, M.D.
Mark V. Ziegler, M.D.

PHYSIOTHERAPY COMMITTEE

Mr. President and Members of the House of Delegates:

The Physiotherapy Committee has been active through its chairman in the State physiotherapy problems.

It appears that the foundation for good physiotherapy in this state is being established and during the years to come, physiotherapy should reach a very desirable level.

A meeting of this committee was attempted at the last annual meeting of the Medical and Chirurgical Faculty, but too many of the members were not able to come. Another meeting will be attempted this year.

Respectfully submitted,
W. Richard Ferguson, M.D., *Chairman*
Moses Gellman, M.D.
H. Alvan Jones, M.D.
Howard F. Kinnamon, M.D.
C. Arthur Rossberg, M.D.
Allen F. Voshell, M.D.

POSTGRADUATE EDUCATIONAL COMMITTEE

Mr. President and Members of the House of Delegates:

The Postgraduate education of physicians is properly divided into two categories. In the first place, there is the in-hospital or residency training of physicians immediately after their graduation from medical school. Secondly, there is the area of continuing education for physicians who have completed their training and who are actively engaged in the practice of medicine or one of its specialties. The committee has felt that it is this latter subdivision of postgraduate education which is of present and immediate concern to the Medical and Chirurgical Faculty of Maryland. The committee realizes, however, that there may come a time in the foreseeable future when it shall become necessary for the Medical and Chirurgical Faculty to concern itself with problems related to the residency training program. Difficulties will arise in this subdivision of postgraduate medical education, particularly as medical insurance plans increase their scope and charity patients of the type currently available for teaching purposes become more scarce.

It is of interest to review the opportunities for continuing medical education now available to practicing physicians. The regular reading of the excellent medical journals which are available today constitutes one important means. The present circulation of the Journal of the American Medical Association exceeds 150,000 copies weekly. While it cannot be assumed that every subscriber reads his journal, it can be said that regular utilization of the material in the journal constitutes one method, and a superb one, of continuing education. The circulations of the specialty journals do not compare with that of the Journal of the American Medical Association but all of these are available in nearly every hospital throughout the state. For those who do not have access to hospital or university libraries, the Medical and Chirurgical Faculty possesses one of the most complete collections in the world.

Meetings of hospital staffs, of county and state societies and of all national groups afford a second means of continuing medical education. In the State of Maryland, there are two regular meetings of the Medical and Chirurgical Faculty each year and a program of educational importance is presented. There is considerable variation from county to county with regard to the educational program of the local society but it should be pointed out that the Medical and Chirurgical Faculty has a standing committee known as the Scientific Speakers Bureau which, upon request of local societies, furnishes qualified speakers from Baltimore. In some counties, there is no educational effort being made. In others, there is a good program. Attention should be called to one excellent attempt on the part of small county societies to compensate for lack of size: the physicians of Kent, Queen Anne's, Caroline, and Talbot counties formed a group, known as the Upper Eastern Shore Medical Society. This organization meets in each of the four counties each year, and conducts a worthwhile program. The Baltimore City Medical Society has recently revised its program and the larger attendance at the regular meetings would seem to indicate approval of the new and more general educational material of the program.

There has been much concern about hospital staff meetings. In some hospitals, particularly those with staff members who are University faculty members as well, the educational program is of high quality; in others, the program is poor. The frequency of meetings and the necessity for attending meetings at several hospitals tend to make these meetings a burden for some. The comment has also been made that those who need education the most are the ones who attend least.

The excellence of the educational programs of such large meetings as the Annual meetings of the American Medical Association, the Southern Medical Association and the American College of Physicians is well-known to all, but published attendance figures do not indicate that large numbers of Maryland physicians avail themselves of these opportunities.

A third method of continuing medical education is attendance at one of the regular, organized courses of postgraduate study or refresher courses which are offered under the auspices of many medical schools, many hospitals and a number of regional medical societies. According to a recent statement of the Council of Medical Education and Hospitals of the American Medical Association, there are more than 1800 different postgraduate programs. In Maryland, a regular postgraduate medical program has been offered by the University of Maryland and, more recently, the Academy of General Practice has entered this field. The Medical and Chirurgical Faculty has not, in recent times, organized or sponsored refresher courses or postgraduate assemblies other than its annual meetings. Due to the geographical position of Maryland, however, such courses are readily available in the District of Columbia, Philadelphia and New York.

Not to be overlooked is the role in continuing medical education played by the detail men and the publications of the large pharmaceutical companies. This activity is delivered willy-nilly right to the office of the physician. Some benefit is, no doubt, derived from this but, in all fairness, it must be pointed out that there is also considerable danger in that physicians may be encouraged to use new drugs or methods without proper understanding of their effects.

The committee believes that there is a considerable group of physicians in the state who regularly avail themselves of the educational opportunities mentioned. There is, however, a large group who do not. In this latter group, there are, no doubt, some who are prevented from taking advantage of the available opportunities because they cannot afford to financially or because their isolation makes it impossible for them to leave their practice. Others, however, have no good reason for not continuing their medical education but do not do so because of inertia or indifference.

It is the opinion of this committee that there are ample opportunities for continuing medical education available to Maryland physicians and that it is not necessary for the Medical and Chirurgical Faculty, at the present time, to sponsor or develop new opportunities. The committee believes, however, that the Medical and Chirurgical Faculty should consider the following two points:

1. The development of means which may make continuing education possible for those who cannot financially afford to attend courses or who cannot leave their practices to attend courses.

2. The development of a practical system which will require physicians to continue their medical education.

The importance of this last point scarcely needs stressing. All too often a physician continues to practice medicine at the level of the period in which he graduated from medical school. The public wants and deserves better. It has been suggested from time to time that periodic re-examination and registration of practicing physicians be introduced. There are many valid objections to such a plan and it does not seem practical at the present time. Competition among physicians would appear to produce the best result in elevating standards of practice. The committee believes that the encouragement of young, well-trained physicians to engage in practice all over the state should be the best means of stimulating the older physicians to keep up with the times, and in this activity the Medical and Chirurgical Faculty should participate.

There appears to be a need in Maryland for a better program to educate the physicians as to the program and activities of the State Health Department. Such a program should be undertaken by the Health Department itself and the committee recommenda to the Medical and Chirurgical Faculty that this suggestion be made to the State Health Department.

Finally, this committee wonders if it would not be to the interest of all concerned to combine it with the Scientific

Speakers Bureau. It would seem that both committees should properly be working in the same area.

Respectfully submitted,
Edward S. Stafford, M.D., *Chairman*
John McC. Culler, M.D.
Robert E. Farber, M.D.
George J. Kreis, M.D.
James T. Marsh, M.D.
Claude W. Mitchell, M.D.
Robert B. Sasscer, M.D.
Edward J. Simon, M.D.
Elizabeth P. Trevett, M.D.
Louis S. Welty, M.D.
Walter L. Winkenwerder, M.D.

COMMITTEE ON PUBLIC INSTRUCTION

Mr. President and Members of the House of Delegates:

By far the most significant health measure in 1952 affecting the people of Baltimore and its surrounding counties—Baltimore, Howard and Anne Arundel—was the fluoridation of the Baltimore City water supply. The attainment of this goal was made possible after more than two years of careful study by the State and City Health Departments, and the State and local medical and dental societies with the assistance of the U. S. Public Health Service. The Medical and Chirurgical Faculty of Maryland gave its whole-hearted support to this program and much information of an educational nature was disseminated to the general public through the various channels of communication—newspapers, periodicals, radio and television. This general public understanding of the value of fluoridation aided immeasurably in promoting the plan to fluoridate the city water supply.

As in past years the fine support of the Medical and Chirurgical Faculty through its individual members contributed largely to the continuation of both weekly radio and television programs sponsored jointly with the City Health Department and radio station WFBR and WMAR-TV. Faculty members gave assistance as advisers in the planning of the program or participated as guest specialists in the program itself, the latter particularly for the television program. The television series which was inaugurated in December, 1948 completed its 209th presentation by the end of 1952. Studio survey ratings during the latter part of the year indicated a viewing audience at times as high as 125,000 persons in the Baltimore area alone, a rating which compares favorably with some popular shows in the entertainment field. It should also be mentioned that correspondence received from viewers indicates that the program is seen by residents in many other parts of the State as well as in adjoining areas. A noteworthy event in this field of public instruction through television was the honoring of "Your Family Doctor," the television series, with an Honorable Mention certificate by the Sixteenth American Exhibition of Educational Radio and Television Programs sponsored by the Institute for Education by Radio and Television at Ohio State University. The certificate reads in part as follows: "In recognition of outstanding educational value and distinguished television production."

The weekly radio series which has been broadcast since 1932 has since 1939 been presented in the form of health dramas. Prior to this time the program was a five minute health talk. While the radio station has not made as strong an effort to evaluate viewing interest as the television station, it can be stated that the radio programs have a popular appeal and serve very satisfactorily as a means of informing the public regarding health matters.

Another venture in health education in which members of the Faculty participated was the drive to inform the public of the importance of testing for diabetes; this was given emphasis especially during National Diabetes Week. In addition to announcements through the press and Health Department publications, and radio and television, assistance was given to the Southeastern Community Council of Baltimore City in the promotion of a combined diabetes and X-ray survey, the first of its kind to be held in Baltimore. Close to 900 persons were checked for both diabetes and tuberculosis. The tuberculosis survey was sponsored by the City Health Department with the assistance of the Maryland Tuberculosis Association and the diabetes tests were performed by volunteers from Sinai Hospital under the supervision of the Director of the Diabetes Clinic there. A house-to-house canvass carried out by the Southeastern Community Council notified residents of the value of these tests, and as in former years Faculty members participated and aided in the educational campaigns sponsored by voluntary health agencies.

The City Health Department contributed largely to public understanding of the problem of lead poisoning in children through the construction of an exhibit on this subject aimed particularly at medical practitioners and other health workers. The exhibit was placed on view at the annual meetings of the following three associations at their request: Southern Branch, American Public Health Association, Baltimore, April, 1952; American Medical Association, Chicago, June, 1952; and American Public Health Association, Cleveland, October, 1952. It is also gratifying to note that this exhibit received a Certificate of Merit award at the AMA meeting in Chicago.

It may be further stated that throughout the year, there was a continuing effort in public information activities on the part of the Committee and its members, through the work of State, County and City health departments and through their work jointly with the profession and directly or indirectly with the public. Records of this work may be found in the periodic health department reports, their regular publications and in their press releases. These reports are available in the respective health departments.

In conclusion, the Committee wishes to state also that it has taken advantage of available opportunities to present medical information to the physician and to the public through meetings and lectures and through the pages of the *Maryland State Medical Journal.*

Respectfully submitted,
Huntington Williams, M.D., *Chairman*
E. I. Baumgartner, M.D.
Page C. Jett, M.D.
William D. Noble, M.D.
Robert H. Riley, M.D.
Peter P. Rodman, M.D.
A. F. Whitsitt, M.D.
Frank D. Worthington, M.D.

COMMITTEE TO CONSIDER THE RELATIONSHIP BETWEEN HOSPITALS AND SPECIALTIES AND THE MANNER OF PAYMENT FOR PROFESSIONAL SERVICES

Mr. President and Members of the House of Delegates:

No cases or matter for discussion has been referred to this Committee during the past year either by the Society, any individual or Hospital.

Respectfully submitted,
Webster H. Brown, M.D., *Chairman*
E. Hollister Davis, M.D.
Merrell L. Stout, M.D.
Henry L. Wollenweber, M.D.

COMMITTEE ON RURAL MEDICINE

Mr. President and Members of the House of Delegates:

The Committee on Rural Medicine had one meeting during the past year, and at that meeting the following points were brought out:

1. In order to interest doctors in locating in rural communities, the junior class of the University of Maryland is being invited to accept preceptorships under rural physicians. We are awaiting notification from Dr. Wylie as to the time when it will be most convenient to discuss this with the junior class this year.

Qualifications outlined for preceptorships were as follows:

(1) Preceptorship must be approved by the local medical society.
(2) Financial arrangements must be a personal one between the student and the physician.
(3) This offer should be submitted to the University of Maryland, Georgetown, and Hopkins medical schools.

2. The Hill-Burton program is going along as fast as the projects can be certified.

3. The Rural Health Committee has been okayed to initiate the formation of Rural Health Councils so as to awaken the rural community to its civic responsibilities and the present trends in medicine, to serve as a nucleus for the various health campaigns, and to be advisory to the local health officer.

4. The prepaid health insurance in rural areas has lagged far behind that in the city largely because of lack of groups. This has been met in many communities through enrollment in Farm Bureau and Homemakers Clubs. However, we recommend that those holding savings accounts in any bank be considered a group and that the premiums be paid by order on the bank, because in rural communities there can be no payroll deduction plan for Blue Cross.

Discussion of the prepaid health insurance brought out the fact that the medical profession, while urging the public to purchase prepaid health and hospital insurance, has done nothing to protect the public from the unscrupulous insurance salesmen. This has resulted first in the public's becoming annoyed with the physician because they do not receive benefits, which loss of benefits is attributed by the agent to the fact that the doctor did not fill out the forms properly, and not to the fact that the patient was not entitled to benefits under that limited policy.

Secondly, the patients are buying mostly indemnity insurance. This is raising the possibility that either the doctor or hospital might not be paid, especially when the indemnity does not cover the cause of illness. It is, therefore, recommended that the House of Delegates initiate a study of prepayment insurance practices and offer some solution such as certification of certain policies as a means of remedying this.

5. This year we saw the initiation of a televised ward rounds and clinics at University Hospital, which makes it feasible in the near future to beam these over closed circuits to medical post-graduate courses in rural communities.

Your chairman visited the Rural Health Conference in Roanoke from February 26–28 and spoke on the Maryland Medical Care Plan. He also learned the definition for a committee, which he would like to pass on to this august body. "A committee is a group of the unwilling, appointed by the uninformed, to do the unnecessary." It makes one wonder if that isn't what we are doing!

Respectfully submitted,
Page C. Jett, M.D., *Chairman*
Morris F. Birely, M.D.
Arthur T. Brice, M.D.
Thomas A. Christensen, M.D.
P. E. Cox, M.D.
Louis H. Douglass, M.D.
John Fawsett, M.D.
J. Stanley Grabill, M.D.
John H. Griffin, M.D.
James W. Meade, Jr., M.D.
Harold B. Plummer, M.D.
Ernest S. Poole, M.D.
Perry F. Prather, M.D.
Walter H. Shealy, M.D.
H. J. Slusher, M.D.
M. H. Sprecher, M.D.

SCIENTIFIC SPEAKERS BUREAU

Mr. President and Members of the House of Delegates:

This is the second report of the Scientific Speakers Bureau, and it was not necessary this year to revise the booklet which contains the names of available speakers and topics. Each Component Medical Society has a copy of this information and this Bureau is glad to supply speakers for medical meetings.

Twelve members have accepted invitations to speak before the Component Medical Societies and the Woman's Medical Society this year. Again, I would like to emphasize that it is imperative that those requesting speakers make application at least four weeks in advance. Every effort will be made to obtain the speaker requested, although we continue to ask that three choices be listed.

Our appreciation is extended to those who have cooperated and accepted invitations to address the various associations. It is only through the sacrifice on the part of those who give up their time to make these addresses that the Scientific Speakers Bureau can function satisfactorily.

Respectfully submitted,
Beverley C. Compton, M.D., *Chairman*
Alan M. Chesney, M.D.
I. Ridgeway Trimble, M.D.
Theodore E. Woodward, M.D.
H. Boyd Wylie, M.D.

ADVISORY COMMITTEE TO THE STATE HEALTH DEPARTMENT

Mr. President and Members of the House of Delegates:

The Committee held a meeting on February 25th, 1953, with representatives from the State Department of Health to discuss a proposal which the Department is considering at the present time but does not intend to put into effect unless the Faculty approves it. Members of the Committee present at the meeting were: Drs. Chesney, McCeney, Pincoffs, Wise, Yeager and Zimmerman. Absent: Drs. Knotts and Williams. Representing the State Department of Health were: Dr. Riley, Director, Dr. Prather, Deputy Director, and Mr. Robert Brown, Director of the Bureau of Environmental Hygiene.

The Department of Health is considering the establishment of a "Program on Home Accident Prevention" under the supervision of its Bureau of Environmental Hygiene, but before actually embarking upon it would like to carry out in the counties of Maryland a preliminary survey to determine the factors involved in fatal accidents other than those which have an industrial or traffic origin. It was pointed out that such a survey would necessitate visits by trained investigators in the employ of the Health Department to families in which such accidents had occurred. Such visits would take place between two and six weeks after the accident, according to present plans.

After a full discussion of the matter the Committee voted to approve in principle a survey by the State Department of Health along the lines indicated. The Committee was unanimously of the opinion that in each instance the approach by the Health Department investigator should be first to the physician of the family concerned and, depending upon his advice, to the family later.

The Committee therefore recommends to the House of Delegates that the proposed survey by the Department of Health of fatal accidents (other than industrial and traffic) in the counties of Maryland be approved, with the qualification that the approach to the family in each instance should be through the family physician.

Respectfully submitted,
Alan M. Chesney, M.D., *Chairman*
Maurice C. Pincoffs, M.D.
Walter D. Wise, M.D.
George H. Yeager, M.D.
E. Paul Knotts, M.D.
Robert S. McCeney, M.D.
Charles H. Williams, M.D.

COMMITTEE TO ADVISE THE STATE ACCIDENT FUND

Mr. President and Members of the House of Delegates:

The Advisory Committee to the State Accident Fund had its first meeting July 23, 1952. At this time its Chairman reported that he had been requested by the Secretary, Mr. Richard K. Coggins to review the records of two industrial accident claims in Prince George's County. This review was made by the Chairman at Prince George's County General Hospital on July 17, 1952. At this time the Chairman found considerable discrepancies in professional fees, not only in these specific cases, but in others as well.

About November 1952 your Chairman met with the Board of the State Accident Fund, after reviewing about 200 histories of reported accidents, treatments, and fees charged. The results of these investigations were reported to your Committee at a meeting December 16, 1952, and a recommendation was made that a part time paid Medical Advisor to the Accident Fund be appointed, to review, and recommend the action of this Board concerning questionable professional charges, and what appeared to be prolonged absenteeism by claimants, out of proportion to their apparent injuries. This recommendation was presented to the State Accident Fund Board by your Chairman, and was accepted by the Board. They then requested that the Committee to Advise the State Accident Fund recommend a suitable person for this position.

At the July meeting of the Committee to Advise the State Accident Fund at the Medical and Chirurgical Faculty building, after careful consideration, it was felt that the proper person for this position should be one experienced with Industrial Surgery, and with Occupational Diseases.

Your Chairman had received a telephone communication from a physician requesting that he be given consideration for this position. He was requested to submit his application in writing, stating his qualifications, and this he did. Though he was a well qualified physician, his records did not show that he ever had any particular training, or experience with Industrial Accidents or Industrial Diseases; therefore this Committee did not give him any consideration. Another name was presented by a member of the Committee. This physician was well qualified in every way, having had a large industrial experience, as well as an acquaintance with industrial diseases. His qualifications were so outstanding that no other person was considered. This physician was approached, and stated that he would accept the position if appointed.

Your Chairman personally presented this recommendation to the State Accident Fund Board. Much to his surprise, a member of this Board took serious objection to this appointment stating that he had personally interviewed the applicant who had telephoned your Chairman, and would be very much embarrassed if he were not appointed. Your Chairman stated that his Committee could only make recommendations, and had no intentions of interfering with any of the prerogatives of the State Accident Fund. It is understood, at a later date the physician of their choice had been appointed.

Under these circumstances, your Chairman does not believe that this Committee is of any value to the State Accident Fund, and feels that it should be discontinued.

Respectfully submitted,
Charles W. Maxson, M.D., *Chairman*
William J. Coleman, M.D.
George O. Eaton, M.D.
William R. Geraghty, M.D.
Donald B. Grove, M.D.
Howard M. Kern, M.D.
James W. Nelson, M.D.
Edward P. Thomas, M.D.

TUBERCULOSIS COMMITTEE

Mr. President and Members of the House of Delegates:

The Tuberculosis Committee of the Medical and Chirurgical Faculty of Maryland met on March 13th, 1953, at which time numerous problems associated with the care of tuberculous patients in the State of Maryland were discussed.

The Committee is pleased to report that since last year, the State Authorities, under the direction of Dr. Hetherington, have been able to discharge patients from the hospitals somewhat sooner than usual and have continued treatment while the patients are at home. The treatment consists mainly of the use of the new anti-tuberculosis drugs.

The City of Baltimore, under the direction of Dr. Silverman, has continued with their policy of treating patients both before and after hospitalization, with which this Committee certainly agrees.

There has been some improvement as regards the waiting lists for admission to the sanatoriums, but not as much as was expected one year ago. As of March 16th, 1953, there were 304 patients, both colored and white, waiting to enter a sanatorium.

While full operation will not be attained for some time because of inadequate staffing and personnel, it is felt that the opening of the new hospital at Mt. Wilson and the new building at the Baltimore City Hospitals will help immeasurably to alleviate the pressing situation.

All of the sanatoria in Maryland are engaged in testing the various anti-tuberculosis drugs, singly and in combination. No definitive report is available as yet, however. There can be no question, however, that the new drugs are playing a big part in the modern treatment of tuberculosis.

I thank the members of this Committee for their cooperation in preparing the above report.

Respectfully submitted,
Lawrence M. Serra, M.D., *Chairman*
Edmund G. Beacham, M.D.
Otto C. Brantigan, M.D.
Leon Hetherington, M.D.
H. Vernon Langeluttig, M.D.
Isadore Lyon, M.D.
John E. Miller, M.D.
Hugh G. Whitehead, Jr., M.D.
Samuel Wolman, M.D.

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

No report.

Samuel McLanahan, M.D., *Chairman;* Drs. W. K. Diehl, W. D. Noble.

REPORT FOR THE BOARD OF TRUSTEES OF MARYLAND MEDICAL SERVICE, INC.

Mr. President and Members of the House of Delegates:

Maryland's Blue Shield Plan has come a long way in its two brief years of existence. It now serves 197,000 Marylanders, 37,000 more than at the end of 1951. Our enrollment gain for 1952 under the standard program was 50 per cent, and nearly half of this gain came after September 1, when changes in the fee schedule and subscription rates materially improved the attractiveness of the Plan. The Plan's income in 1952 went over the million dollar mark and of this amount, 83.6% was paid in benefits to subscribers. Compared with the early record of Blue Cross—a remarkable story of progress in itself—our growth has been steady and healthy, and a certain amount of optimism seems justified.

Despite its successful progress, Blue Shield still has far to go to meet its basic obligation—an adequate and effective means of financing physicians services for as many persons in the community as possible, at a price they can afford to pay.

Let us analyze this objective. Is the protection adequate? It seems as nearly so as we can make it right now, although in time we will probably wish to broaden it. Last year we paid benefits to about one in every ten persons enrolled. Of these cases, under our own Plan (excluding the special surgical program for Bethlehem Steel employees) 60% of the cases involved surgery, 31% were medical, and the remaining 9%, obstetrical. These figures show the importance of our medical coverage, which is not always available elsewhere under Blue Shield, or commercial insurance programs.

Is the price one the great majority can afford to pay? Apparently it is, judging from our own experience and that of Blue Shield Plans in other areas. Whether it could be increased in order to broaden benefits is a question that must some day be studied.

But what of our objective to make Blue Shield available to as many persons as possible? Here we have only scratched the surface of our potential market. We have enrolled only 22% of the Blue Cross membership. A tremendous selling job remains to be done, and this is not easy, since we find that in the majority of large groups we have to replace an existing commercial coverage taken out in the years before Blue Shield was in existence.

One of the most important features of Blue Shield—one that could and should be the most important—is the service benefit feature whereunder participating physicians agree to make no additional charge for covered services to individuals and families with annual incomes less than the pre-established amounts.

This is the one factor that distinguishes Blue Shield from commercial health insurance.

To persons in the lower income brackets, this service benefit feature means full protection against unexpected medical bills. They get the best medical care, and are able to budget for it in advance through membership in Blue Shield.

In agreeing to provide services at pre-determined fees to persons in the lower income brackets, the physician is not deviating from the established practice of charging patients according to their ability to pay. At the same time he is providing real service to the community.

The phenomenal growth of Blue Shield—24 million members nationally—has been one of the chief factors (along with the growth of Blue Cross) in persuading the proponents of Federal compulsory health insurance that the provision and financing of medical care for the self-supporting population can be achieved on a voluntary basis.

Blue Shield is our creation. It is controlled here and elsewhere by the medical profession. We collect the money and undertake to provide the services of qualified physicians, which is right and proper since our interest is paramount. But with our control goes responsibility, and with responsibility goes opportunity. If any other agency, in or out of Government, undertook to provide the public with professional services, we would lose control of medical practice.

The continued success of Blue Shield will depend entirely upon the degree of our voluntary cooperation and participation. Hence, we must endorse Blue Shield to our patients and friends. By so doing we will bring the program closer to its objective—an adequate and effective means of financing medical care for as many persons as possible at a price they can afford to pay—and we will have rendered a real service to our patients, to the community, and to ourselves.

Respectfully submitted,
HUGH J. JEWETT, M.D., *President*

* * * * *

CONFERENCE FOR INDUSTRIAL PHYSICIANS AND NURSES

Rheumatic Disorders in Industry—Techniques for Keeping Arthritics Employable

TUESDAY, SEPTEMBER 22, 1953—8:00 P.M. to 10:30 P.M.

Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore

Under the co-sponsorship of the Maryland Chapter of the Arthritis and Rheumatism Foundation and the Committee of Industrial Health of the Medical and Chirurgical Faculty, a Conference on Rheumatic Disorders in Industry will be held in the auditorium of the Medical and Chirurgical Faculty on the evening of Tuesday, September 22nd from 8:00 to 10:30 P.M.

The conference, to which all Industrial Physicians and Industrial Nurses in Maryland are invited, will center around techniques for keeping arthritis patients employable.

Arrangements for this conference are under the direction of Dr. Charles Wainwright and Dr. D. W. Saunders, who are serving as co-chairmen. In addition to Dr. Saunders and Dr. Wainwright, the program committee consists of Dr. Nathan B. Herman, Dr. Walter E. Fleisher and Dr. Leon E. Kochman.

The program will consist of three one-half hour talks by Dr. Joseph B. Bunim, Director of Arthritis Research at the National Institute of Health, Dr. Charles S. Wise, Professor of Physical Medicine at the George Washington School of Medicine, and Dr. Wainwright. Dr. Bunim will outline the problem caused by Arthritis within industry. Dr. Wise will discuss means of keeping Arthritics employable, and Dr. Wainwright will explain in what ways the Maryland Chapter of the Arthritis and Rheumatism Foundation can best cooperate with industry.

These three talks will be scheduled to run from 8:00 P.M. to 9:45 P.M., and from 10:00 P.M. to 10:30 P.M. will be reserved for questions and answers.

Each year industry suffers a tremendous loss of man hours due to Arthritis and Rheumatism. According to studies, approximately 800,000 factory workers are afflicted with Rheumatic diseases; skilled craftsmen in industry run a close second, with an estimated 575,000; and those engaged in the sales end of industry suffering from the Rheumatic diseases number almost 200,000.

Much of this drain upon industry is avoidable. It is believed that about 70% of the crippling effects of Arthritis can be prevented if diagnosed early and treated properly.

Mr. Willard G. Rouse, Assistant Treasurer of the Mathieson Chemical Company, is President of the Maryland Chapter of the Arthritis and Rheumatism Foundation. Dr. Harry F. Klinefelter, Jr., is Vice President and Chairman of the Medical and Scientific Committee. Mr. D. C. W. Ward, Jr., Vice President of the Union Trust Company is serving as the Chapter's Secretary and Mr. Walter N. Kirkman, Executive Director of the Medical and Chirurgical Faculty is Secretary. Mrs. Noble C. Powell is Chairman of the Women's Committee. Dr. Nathan B. Herman is Chairman of the Faculty's Committee on Industrial Health.

Headquarters of the Arthritis and Rheumatism Foundation are in Room 1116 of the Fidelity Building, Baltimore 1. The telephone number is LE. 9-8502. The Chapter will welcome all requests for information and all suggestions as to how it may best serve the Medical Profession and those suffering from Arthritis.

* * * * *

OFFICERS, PERSONNEL OF COMMITTEES, ETC.[1]

Reprinted from the Annual Meeting Program for 1953

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

OFFICERS

President—Maurice C. Pincoffs, Baltimore
Vice-Presidents—George O. Eaton, Baltimore; Osborne D. Christensen, Salisbury; William F. Williams, Cumberland
Treasurer—J. Albert Chatard, Baltimore
Secretary—George H. Yeager, Baltimore
Assistant Secretary—Everett S. Diggs, Baltimore

COUNCILORS[2]

	Term Expires
C. Reid Edwards, *Chairman*, Baltimore	1953
E. Cowles Andrus, *Vice-Chairman*, Baltimore	1954
O. H. Binkley, Hagerstown	1953
James T. Marsh, Westminster	1953
W. O. McLane, Frostburg	1953
Thomas A. Christensen, College Park	1954
Monte Edwards, Baltimore	1954
Warfield M. Firor, Baltimore	1954
Whitmer B. Firor, Baltimore	1954
William D. Noble, Easton	1954
Palmer F. C. Williams, Pikesville	1954
Charles R. Austrian, Baltimore	1955
Hugh J. Jewett, Baltimore	1955
William B. Long, Salisbury	1955
Walter D. Wise, Baltimore	1955
Maurice C. Pincoffs, *President*, Baltimore	1953
J. Albert Chatard, *Treasurer*, Baltimore	1953
George H. Yeager, *Secretary*, Baltimore	1953
Everett S. Diggs, *Assistant Secretary*, Baltimore	1953
Alan M. Chesney, *Past President*, Baltimore	1953
President-elect	1953
Louis Krause, *Chairman of Library Committee*, Baltimore	1955
John W. Parsons, *A.M.A. Delegate*, Baltimore	1953
Warde B. Allen, *A.M.A. Delegate*, Baltimore	1954

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

	Term Expires
Delegate—John W. Parsons, Baltimore; *Alternate*, Benjamin S. Rich, Baltimore	1953
Delegate—Warde B. Allan, Baltimore; *Alternate*, Louis H. Douglass, Baltimore	1954

MEMBERS OF THE BOARD OF MEDICAL EXAMINERS

	Term Expires
Erasmus H. Kloman, *President*, Baltimore	1955
Lewis P. Gundry, *Secretary-Treasurer*, Baltimore	1954
Henry T. Collenberg, Baltimore	1953
E. Paul Knotts, Denton	1953
Edward P. Thomas, Frederick	1954
John H. Hornbaker, Hagerstown	1955
John E. Legge, Baltimore	1956
Edward M. Hanrahan, Baltimore (deceased)	1956

ELECTED COMMITTEES

Committee on Scientific Work and Arrangements

Beverley C. Compton, *Chairman*, Baltimore
William L. Garlick, Baltimore
Edwin H. Stewart, Jr., Baltimore

Library Committee

	Term Expires
Louis Krause, *Chairman*, Baltimore	1955
Samuel Wolman, Baltimore	1953
John T. King, Baltimore	1954
A. Austin Pearre, Frederick	1956
William K. Diehl, Baltimore	1957
Joseph C. Biddix, Jr., D.D.S., Baltimore	

Finney Fund Committee

	Term Expires
Douglas H. Stone, *Senior Member*, Baltimore	1953
Henry M. Thomas, Baltimore	1954
John M. T. Finney, Jr., Baltimore	1955
Louis P. Hamburger, Baltimore	1956
I. Ridgeway Trimble, Baltimore	1957

COMMITTEES—AS PROVIDED IN THE CONSTITUTION AND BY-LAWS

Executive Committee of the Council

(Chairman of the Council, President, Secretary and Treasurer.)
C. Reid Edwards, *Chairman of Council*, Baltimore
Maurice C. Pincoffs, *President*, Baltimore
George H. Yeager, *Secretary*, Baltimore
J. Albert Chatard, *Treasurer*, Baltimore

---

[1] For Presidential appointments of Committees, made by Dr. Maurice C. Pincoffs for 1953, see pages 117–119, Maryland State Medical Journal, Vol. 2, No. 3, March 1953.

[2] Council meets on the first Tuesday of February, April, June, October and December. Special meetings may be called.

The House Committee

(Executive Committee plus the Chairman of the Library Committee.)

C. Reid Edwards, *Chairman of Council*, Baltimore
Maurice C. Pincoffs, *President*, Baltimore
George H. Yeager, *Secretary*, Baltimore
J. Albert Chatard, *Treasurer*, Baltimore
Louis Krause, *Chairman Library Committee*, Baltimore

Finance Committee

(Five members, namely, the Chairman of the Council, the Treasurer, the Secretary, and two members of the Faculty appointed by the Chairman of the Council.)

C. Reid Edwards, *Chairman of Council*, Baltimore
J. Albert Chatard, *Treasurer*, Baltimore
George H. Yeager, *Secretary*, Baltimore
Charles R. Austrian, Baltimore
R. Walter Graham, Jr., Baltimore

Professional Conduct Committee

(Five immediate Past Presidents and Chairman of the Council, with the Senior Past President as Chairman.)

Charles W. Maxson, Past President (1948), *Chairman*, Baltimore
Alan M. Chesney, Past President (1952), Baltimore
Walter D. Wise, Past President (1951), Baltimore
A. Austin Pearre, Past President (1950), Frederick
W. Houston Toulson, Past President (1949), Baltimore
C. Reid Edwards, *Chairman of Council*, Baltimore
Maurice C. Pincoffs, *ex officio*, Baltimore
J. Albert Chatard, *ex officio*, Baltimore
George H. Yeager, *ex officio*, Baltimore

Resolutions Committee

(Five members to be appointed annually by the President of the Medical and Chirurgical Faculty, who shall also designate the Chairman.)

William D. Noble, *Chairman*, Easton
Charles R. Austrian, Baltimore
Robert V. Campbell, Hagerstown
F. Ford Loker, Baltimore
M. C. Porterfield, Hampstead

* * * * * * * * * * * * * * * * * *

Specially Appointed
Medical Advisory Committee to Selective Service
R. Walter Graham, Jr., *Chairman*, Baltimore

* * * * * * * * * * * * * * * * * *

SPECIAL COMMITTEES REPORTING TO THE HOUSE OF DELEGATES

Committee for Better Distribution of Doctors Throughout the State

Allen F. Voshell, *Chairman*, Baltimore
E. I. Baumgartner, Oakland
A. M. France, Parkton
I. Rivers Hanson, Salisbury
Richard T. Shackelford, Baltimore

Committee to Study an Insurance Problem

William L. Garlick, *Chairman*, Baltimore
John W. Parsons, Baltimore
Alexander J. Schaffer, Baltimore

Committee for the Study of Certain Phases of Medical Economics

Waldo B. Moyers, *Chairman*, Mt. Rainier
Wolcott L. Etienne, College Park
Houston S. Everett, Baltimore
Thomas K. Galvin, Baltimore
Frank J. Otenasek, Baltimore

Committee to Study Legislative and Professional Standards and Staff Relations of Hospitals

Ross Z. Pierpont, *Chairman*, Baltimore
Ernest I. Cornbrooks, Jr., Baltimore
Russell A. Nelson, Baltimore
Merrell L. Stout, Baltimore
William H. F. Warthen, Towson

OFFICERS AND DELEGATES OF COMPONENT MEDICAL SOCIETIES

Allegany-Garrett County. *President*, W. Royce Hodges, Cumberland; *Vice-President*, W. O. McLane, Jr., Frostburg; *Secretary*, R. Rhett Rathbone, Cumberland; *Treasurer*, Leland B. Ranson, Cumberland; *Delegates*, Emmett L. Jones, Jr., Cumberland; James T. Johnson, Jr., Cumberland; *Alternate*, Clay E. Durrett, Cumberland; Donald B. Grove, Cumberland. *Journal Representative*, Leslie E. Daugherty, Cumberland. *Meetings*, Third Friday each month, Ali Ghan Shrine Club.

Anne Arundel County. *President*, J. Oliver Purvis, Annapolis; *Vice-President*, William J. French, Annapolis; *Secretary-Treasurer*, J. Howard Beard, Annapolis; *Delegate*, Bowie L. Grant, Shadyside; *Alternate*, William N. Thomas, Jr., Annapolis. *Journal Representative*, George C. Basil, Annapolis. *Meetings*, January, April, July and October.

Baltimore County. *President*, Charles F. O'Donnell, Baltimore; *Vice-President*, Martin Strobel, Baltimore; *Secretary-Treasurer*, Thomas E. Wheeler, Randallstown; *Delegates*, David H. Andrew, Baltimore; James G. Howell, Catonsville; Melvin B. Davis, Dundalk; *Alternates*, Louis Z. Dalmau, Pikesville; Harry G. Butler, Owings Mills; Wilmer K. Gallager, Catonsville. *Journal Representative*, Donald L. Somerville, Towson. *Meetings*, Third Wednesday of each month.

Baltimore City. *President*, Wetherbee Fort; *Vice-President*, Lewis P. Gundry; *Secretary*, Edward F. Cotter; *Treasurer*, Robert C. Kimberly. *Journal Representative*, Conrad Acton. 1952–1953: *Delegates*, Helen Bowie, Ferdinand E. Chatard, IV, William E. Gilmore, Robert F. Healy, James R. Karns, J. H. Mason Knox III, Franklin E. Leslie, Hugh B. Mc-

Nally, W. Kenneth Mansfield, H. William Primakoff, W. H. Townshend, Jr. *Alternates*, I. William Nachlas, Douglas H. Stone, Herbert E. Wilgis, Cecil H. Bagley, Webster H. Brown, Katherine H. Borkovich, Joseph Gordon Bird, Walter S. Niblett, Nathan E. Needle, Lester A. Wall, Jr., Daniel J. Pessagno. 1953: *Delegates*, Bernard J. Cohen, Palmer H. Futcher. *Alternates*, James N. McCosh, John Newell Classen. 1953–1954: *Delegates*, Conrad Acton, John S. Fenby, Wilson Grubb, John M. Haws, Harry F. Klinefelter, Jr., Zachariah R. Morgan, Edmund R. Novak, Thomas R. O'Rourk, Frank J. Otenasek, Ross Z. Pierpont, John E. Savage, Richard T. Shackelford, W. Kennedy Waller, Theodore E. Woodward. *Alternates*, M. Paul Byerly, Charles R. Goldsborough, Raymond E. Lenhard, Edwin B. Jarrett, D. C. MacLaughlin, James W. Nelson, John M. Scott, Mary L. Hayleck, Otto C. Brantigan, Carleton C. Douglass, George W. Murgatroyd, Jr., Edward F. Lewison, J. Brooke Boyle, Jr., Howard M. Bubert. *Meetings*, Third Friday of each month, October through April.

Calvert County. *President*, Hugh W. Ward, Owings; *Vice-President*, George J. Weems, Huntingtown; *Secretary-Treasurer*, Page C. Jett, Prince Frederick; *Delegate*, George J. Weems, Huntingtown; *Alternate*, Robert de Villarreal, Prince Frederick. *Journal Representative*, Page C. Jett, Prince Frederick. *Meetings*, First Tuesday in December to elect Officers, other meetings on call.

Caroline County. *President*, Charles H. Winnacott, Ridgely; *Vice-President*, Robert Wright, Greensboro; *Secretary-Treasurer*, Edwin G. Riley, Denton; *Delegate*, Dawson O. George, Denton; *Alternate*, H. Fletcher Silver, Goldsboro. *Journal Representative*, Robert Wright, Greensboro. *Meetings*, On call, also meet with Upper Eastern Shore Medical Association.

Carroll County. *President*, Merritt Robertson, New Windsor; *Vice-President*, William Culwell, Mt. Airy; *Secretary-Treasurer*, W. H. Foard, Manchester; *Delegate*, M. C. Porterfield, Hampstead; *Alternate*, Robert E. Gardner, Sykesville. *Journal Representative*, W. H. Foard, Manchester. *Meetings*, Third Wednesday of every other month, except July and August.

Cecil County, *President*, S. Ralph Andrews, Elkton; *Vice-President*, John M. Byers, Elkton; *Secretary-Treasurer*, Richard C. Dodson, Rising Sun; *Delegate*, Richard C. Dodson, Rising Sun; *Alternate*, George J. Kreis, Jr., Elkton. *Journal Representative*, Richard C. Dodson, Rising Sun. *Meetings.*—

Charles County. *President*, James E. Andrews, Indian Head; *Vice-President*, Edward J. Edelen, La Plata; *Secretary-Treasurer*, J. Parran Jarboe, La Plata; *Delegate*, Arthur O. Wooddy, La Plata; *Alternate*, John H. Griffin, Hughesville. *Journal Representative*, J. Parran Jarboe, La Plata. *Meetings*, Second Thursday of each month, September to June, 8:30 p.m., Jarwood Clinic, La Plata.

Dorchester County. *President*, John Mace, Jr., Cambridge; *Vice-President*, Robert H. Reddick, Cambridge; *Secretary-Treasurer*, Walter B. Johnson, Cambridge; *Delegate*, William H. Hanks, Cambridge; *Alternate*, Frederick A. Miller, Cambridge. *Journal Representative*, Walter B. Johnson, Cambridge. *Meetings*, Third Wednesday of each month.

Frederick County. *President*, James E. Stoner, Jr., Walkersville; *Vice-President*, Bernard O. Thomas, Jr., Frederick; *2nd Vice-President*, Thomas H. Quill, Frederick; *Treasurer*, John M. Culler, Frederick; *Secretary*, Jesse S. Fifer, Frederick; *Delegate*, J. Elmer Harp, Middletown; *Alternate*, Rex R. Martin, Frederick. *Journal Representative*, Jesse S. Fifer, Frederick. *Meetings*, Third Tuesday in every month, except July and August.

Harford County. *President*, Robert Barthel, Forest Hill; *Secretary-Treasurer*, Charles R. Hayman, Bel Air; *Delegate*, Peter P. Rodman, Aberdeen; *Alternate*, Richard C. Norment, III, Havre de Grace. *Journal Representative*, Robert Barthel, Forest Hill. *Meetings*, Third Sunday, every other month.

Howard County.* *President*, George E. Burgtorf, Jr., Ellicott City; *Vice-President*, George E. Groleau, Elkridge; *Secretary-Treasurer*, Theodore R. Shrop, Ellicott City; *Delegate*, Frank E. Shipley, Savage; *Alternate*, B. B. Brumbaugh, Elkridge. *Journal Representative*, Theodore R. Shrop, Ellicott City. *Meetings*, Fourth Friday of every other month, beginning in January.

Kent County. *President*, A. C. Dick, Chestertown; *Secretary-Treasurer*, O. S. Gulbrandsen, Chestertown; *Delegate*, A. F. Whitsitt, Chestertown; *Alternate*, Robert W. Farr, Chestertown. *Journal Representative*, O. S. Gulbrandsen, Chestertown. *Meetings*, On call.

Montgomery County. *President*, William S. Murphy, Rockville; *Vice-President*, Austin B. Rohrbaugh, Jr., Chevy Chase; *Secretary*, L. Marshall Cuvillier, Jr., Silver Spring; *Treasurer*, Henry P. Laughlin, Chevy Chase; *Delegates*, Claude W. Mitchell, Silver Spring; William W. Welsh, Rockville; J. W. Bird, Sandy Spring; Read N. Calvert, Silver Spring; *Alternates*, John G. Ball, Bethesda; McKendree Boyer, Damascus; John O. Robben, Silver Spring; Frank A. Zack, Silver Spring. *Journal Representative*, Charles I. Warfield, Silver Spring. *Meetings*, Third Tuesday of each month.

Prince George's County. *President*, John M. Warren, Laurel; *Vice-President*, Julius Kauffman, Bladensburg; *Corresponding Secretary*, Richard D. Bauer, Hyattsville; *Recording Secretary*, Hans Wodak, Greenbelt; *Treasurer*, Benjamin S. Miller, Mt. Rainier; *Delegates*, Waldo B. Moyers, Mt. Rainier; Wolcott L. Etienne, College Park; *Alternates*, William Brainin, Capitol Heights; Robert B. Sasscer, Upper Marlboro. *Journal Representative*, John M. Warren, Laurel. *Meetings*, First Tuesday of each month.

Queen Anne's County. *President*, Theodor Sattelmaier, Stevensville; *Vice-President*, C. Rodney Layton, Centreville; *Secretary-Treasurer*, Frederick P. Shepherd, Queenstown; *Delegate*, Norman S. Dudley, Church Hill; *Alternate*, W. H. Fisher, Centreville. *Journal Representative*, G. W. Martin, Jr., Queenstown. *Meetings*, November, February and May.

St. Mary's County. *President*, P. J. Bean, Great Mills; *Vice-President*, W. H. Patrick, Lexington Park; *Secretary-Treasurer*, J. Roy Guyther, Mechanicsville; *Delegate*, Alan D. Houser, Leonardtown; *Alternate*, W. D. Boyd, Leonardtown. *Journal Representative*, J. Roy Guyther, Mechanicsville. *Meetings*, Combined meeting with monthly staff meeting of St. Mary's Hospital, first Tuesday of each month.

---

* Hold-over officers.

Somerset County. *President*, C. G. Rawley, Crisfield; *Vice-President*, Robert F. Lewis, Crisfield; *Secretary-Treasurer*, Robert H. Johnson, Princess Anne; *Delegate*, T. B. Whaley, Princess Anne; *Alternate*, George C. Coulbourn, Marion Station. *Journal Representative*, A. N. Barr, Crisfield. *Meetings*, Called.

Talbot County. *President*, J. E. Baybutt, Easton; *1st Vice-President*, Kurt Lederer, Queen Anne; *2nd Vice-President*, J. F. Schneider, Easton; *Secretary-Treasurer*, Louis S. Welty, Easton; *Delegate*, D. F. Bartley, Easton; *Alternate*, E. C. H. Schmidt, Easton. *Journal Representative*, Louis S. Welty, Easton. *Meetings*, One regular meeting in December. Meet with Upper Eastern Shore Society (Talbot, Kent, Queen Anne's and Caroline) four times a year, once in each County. October meeting in Talbot County.

Washington County. *President*, Ira L. Houghton, Hagerstown; *Vice-President*, Archie R. Cohen, Clear Spring; *Secretary-Treasurer*, Ernest F. Poole, Hagerstown; *Delegate*, R. V. Campbell, Hagerstown; *Alternate*, W. T. Layman, Hagerstown. *Journal Representative*, O. D. Sprecher, Hagerstown. *Meetings*, First Thursday in January, April, July and October.

Wicomico County. *President*, David J. Gilmore, Salisbury; *Vice-President*, William C. Morgan, Salisbury; *Secretary-Treasurer*, Wilber R. Ellis, Jr., Salisbury; *Delegate*, Hunter R. Mann, Jr., Salisbury; *Alternate*, Stedman W. Smith, Salisbury. *Journal Representative*, Hunter R. Mann, Jr., Salisbury. *Meetings*, Once a month.

Worcester County. *President*, Norman E. Sartorius, Sr., Pocomoke City; *Vice-President*, Herman A. Robbins, Berlin; *Secretary-Treasurer*, Louis G. Llewelyn, Pocomoke City; *Delegate*, Norman E. Sartorius, Jr., Pocomoke City; *Alternate*, Louis G. Llewelyn, Pocomoke City. *Journal Representative*, Louis G. Llewelyn, Pocomoke City. *Meetings*, Four times a year, January, April, July and October.

PERTINENT INFORMATION FROM ANNUAL MEETING PROGRAM, 1953*

CREATIVE ARTS SHOW

Frick Reading Room, Library Floor

Medical and Chirurgical Faculty Building

This show was arranged and planned under the auspices of a Committee of the Woman's Auxiliary to the Medical and Chirurgical Faculty consisting of Mrs. Beverley C. Compton, *Chairman*, Mrs. Frank R. Smith, Jr., *Co-Chairman*, Mrs. Thomas R. Chambers, Mrs. Everett S. Diggs, Mrs. A. Murray Fisher, Mrs. Marius P. Johnson, Mrs. John W. Parsons, Mrs. Benjamin H. Rutledge, Mrs. Howard C. Smith, and Mrs. I. Ridgeway Trimble.

ENTRIES

Mrs. William R. Amberson, Cockeysville	Oil Paintings
Mrs. John A. Askin, Baltimore	Oil Paintings
Mrs. Charles R. Austrian, Baltimore	Oil Paintings
Dr. Henry T. Bahnson, Baltimore	Wood Carving
Dr. Margaret B. Ballard, Baltimore	Needle Point
Mrs. Clarence I. Benson, Port Deposit	Oil Paintings
Dr. Howard M. Bubert, Baltimore	Photography
Dr. Katharine A. Chapman, Kensington	Embroidery
Mrs. Louis Z. Dalmau, Pikesville	Oil Paintings
Mrs. A. Murray Fisher, Ruxton	Sculpture
Dr. Wetherbee Fort, Baltimore	Walnut Shelf
Mrs. Abraham Genecin, Baltimore	Oil Paintings
Dr. Lyle L. Gordy, Baltimore	Oil Paintings
Mrs. Edward Gordon Grau, Towson	Oil Paintings
Mrs. Joseph B. Gross, Baltimore	Oil Paintings, Wood Carving, and Toleware
Dr. Wilson Grubb, Baltimore	Color Photography
Mrs. William T. Hammond, Easton	Oil Painting, Water Colors, and Needle Point
Dr. Gustav Highstein, Baltimore	Oil Painting and Water Color
Dr. Henry W. D. Holljes, Baltimore	Water Colors
Mrs. Henry W. D. Holljes, Baltimore	Water Colors
Dr. Calvin Hyman, Baltimore	Charcoal and Oil Painting
Faye Marie Johnson, Baltimore (daughter of Dr. Wm. R. Johnson)	Metal Lamp
Dr. Ilse Kamm, Sykesville	Oil Paintings
Dr. K. Kenneth Krulevitz, Baltimore	Water Colors and Oil Painting
Dr. Stanley H. Macht, Hagerstown	Oil Paintings and Model Airplane (gas motor)
Mrs. Donald D. Mark, Baltimore	Charcoal, Oil Painting, and Sculpture
Dr. Donald D. Mark, Baltimore	Photography
Dr. Marcus W. Moore, Sr., Baltimore	Photographs
Mrs. Frederick Musser, Hyattsville	Ceramics
Mrs. Nathan E. Needle, Baltimore	Oil Paintings
Mrs. Willard S. Parson, Baltimore	Ceramics
Mrs. John W. Parsons, Baltimore	Oil Painting
Mrs. J. W. Perkins, Cheverly	Ceramics
Dr. Donald F. Proctor, Baltimore	Wood Carving
Mrs. Donald F. Proctor, Baltimore	Oil Painting and Water Color
Dr. Nathan Schnaper, Baltimore	Sculpture
Dr. Roy O. Scholz, Baltimore	Photography
Mrs. Isadore A. Siegel, Baltimore	Ceramic Bread Dish
Dr. Jerome Snyder, Baltimore	Oil Paintings
Mrs. William Stecher, Burnt Mills Hills	Paintings
Dr. Charles L. Warner, Baltimore	Pastels

---

* Scientific Program published in Vol. 2, No. 3, March 1953, pages 109–114.

Mrs. William H. F. Warthen, Towson . . Toleware
Mrs. George E. Wells, Jr., Baltimore . . . . Oil Painting and Pastels
Dr. George E. Wells, Jr., Baltimore . . . Oil Paintings
Mrs. Walter L. Winkenwerder, Glyndon . . . . Oil Painting

* * * * *

COMMERCIAL EXHIBITORS

Prominent firms, dealing in books and supplies required by physicians, as listed below, exhibited during the Annual Meeting of the Medical and Chirurgical Faculty.

Our thanks are extended to Hynson, Westcott & Dunning, Inc., who have kindly contributed to our Annual Meeting, although it was not convenient for them to exhibit.

We wish to express our appreciation to the Coca-Cola Bottling Company of Baltimore and the Seven-Up Bottling Company of Baltimore for the serving of free Coca-Cola and Seven-Up to those attending the Meeting.

1. A. S. Aloe Company
2. Ayerst, McKenna & Harrison Limited
3. Beech-Nut Packing Company
4. A. J. Buck & Son
5. Coca-Cola Bottling Company of Baltimore
6. Herbert Cox—Correct Shoes
7. Desitin Chemical Company
8. The Doho Chemical Corporation
9. Graymar Company
10. Caroline deFord Hinrichs
11. Irwin, Neisler & Company
12. Kloman Instrument Company, Inc.
13. The Liebel-Flarsheim Company
14. Eli Lilly & Company
15. Massachusetts Indemnity Insurance Company
16. Mead Johnson & Company
17. Murray-Baumgartner Surgical Instrument Company, Inc.
18. Nepera Chemical Company, Inc.
19. Niagara Health Equipment Company
20. Ortho Pharmaceutical Corporation
21. Parke, Davis & Company
22. Charles Pfizer & Company, Inc.
23. William P. Poythress & Company, Inc.
24. A. H. Robins Company, Inc.
25. W. B. Saunders Company
26. G. D. Searle & Company
27. Seven-Up Bottling Company of Baltimore
28. Similac Division, M & R Laboratories
29. Raymond K. Tongue Company, Inc. (Commercial Insurance Company)
30. The Upjohn Company
31. U. S. Vitamin Corporation
32. Walker Laboratories, Inc.
33. The Williams & Wilkins Company

SUBCOMMITTEE ON EXHIBITS

Edwin H. Stewart, Jr., M.D., *Chairman*, Baltimore
Michael I. O'Connor, Baltimore
John A. Strevig, Phar.D., Baltimore

* * * * *

AUTOPSY LAW NOW IN EFFECT

New Addition to Maryland Code Clarifies Permission for Autopsy

At the suggestion of the Maryland Society of Pathologists, Inc., and with the efforts of State Senators John Grason Turnbull (Democrat, Baltimore County) and Omar D. Crothers (Democrat, Cecil, and Chairman of the Judicial Proceedings Committee of the Maryland State Senate) a bill which might be entitled The Maryland Autopsy Bill was recently signed into law by Governor McKeldin, becoming effective on June 1, 1953. This new law clarifies and defines several different issues which have at times in the past caused considerable difficulty for hospital administrators, members of the intern and resident staffs, and hospital pathologists. In brief, the law defines the type of voluntary permission and specifically defines those who may grant permission for postmortem examination. Furthermore, in the event of the absence of certain next-of-kin, the law defines the person who may grant permission. Contained in the statute also are provisions for permission when more than one next-of-kin is concerned. Exact wording of the new law is published below.

"Enacted by the General Assembly of Maryland—1953 Session To Become Section 147A of Article 43 of the Annotated Code of Maryland to be Effective June 1, 1953–

147A—Written or telegraphic consent for a Doctor of Medicine to conduct a post mortem examination of the body of a deceased person shall be deemed sufficient when given by whichever one of the following assumes custody of the body for purposes of burial: father, mother, husband, wife, child, guardian, next-of-kin, or in absence of any of the foregoing, a person who assumes the duty of legal disposal of the body, consent of one of them shall be deemed sufficient."

The Maryland Society of Pathologists, Inc., through its president, Dr. Russell S. Fisher, has undertaken to circularize all pathologists and hospital administrators, sending them ample supplies of copies of the new law. Physicians interested in securing copies of this new law may obtain them through Dr. Russell S. Fisher, 700 Fleet Street, Baltimore 2, Maryland.

State of Maryland Department of Health

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, July 3–30, 1953

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCAL	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County	2	—	1	2	14	1	34	11	12	1	6	—	—	5	23	—	15	—	9
Anne Arundel	2	—	1	2	—	1	6	1	1	2	1	—	—	1	1	—	4	t-1	1
Howard	—	—	—	—	—	—	2	1	—	—	1	—	—	—	2	—	—	—	—
Harford	1	—	4	4	3	—	3	—	1	—	—	—	—	3	9	—	—	m-1	—
Carroll	—	—	—	1	2	—	3	2	—	—	—	—	—	—	1	—	1	—	2
Frederick	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	3	—	2
Washington	—	—	—	—	1	—	1	1	—	—	1	—	—	—	2	—	3	—	—
Allegany	—	—	—	2	3	—	—	—	—	—	1	1	—	—	24	—	1	—	1
Garrett	—	—	—	2	—	—	—	—	—	—	—	—	—	—	1	—	2	—	—
Montgomery	2	—	—	3	7	1	29	15	12	1	—	—	1	1	8	—	4	—	2
Pr. George's	1	—	4	2	5	—	15	2	4	—	—	—	—	—	7	—	1	—	2
Calvert	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	1	—	—
Charles	—	—	—	—	—	—	1	—	2	—	—	1	—	—	1	—	1	—	—
Saint Mary's	—	—	—	3	—	—	—	—	1	1	—	—	—	—	1	—	—	—	—
Cecil	—	—	—	—	—	—	—	—	—	—	—	—	1	—	3	—	5	—	1
Kent	1	—	—	—	3	—	5	—	—	—	—	—	—	—	—	—	2	—	—
Queen Anne's	—	—	—	—	4	—	—	1	—	1	—	—	—	—	—	—	—	—	—
Caroline	—	—	—	—	—	—	1	1	—	—	—	—	—	—	—	—	1	—	—
Talbot	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	7	—	—
Dorchester	—	—	—	—	—	—	—	—	—	—	—	—	—	—	7	—	18	—	—
Wicomico	—	—	—	1	2	—	3	—	—	—	—	—	—	1	1	—	6	—	1
Worcester	—	—	—	—	1	—	—	—	—	—	—	—	—	10	3	3	1	—	1
Somerset	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1
Total Counties	9	0	10	22	45	3	105	35	33	6	10	2	2	21	96	3	76		23
Baltimore City	16	0	5	11	44	0	127	13	13	2	15	0	0	30	88	8	552	c-2	18
State																			
July 3–30, 1953	25	0	15	33	89	3	232	48	46	8	25	2	2	51	184	11	628		41
Same period 1952	88	0	25	15	102	5	72	12	3	8	10	3	0	10	220	14	645		35
5-year median	75	4	23	—	186	2	116	23		13	22	4	2	71	223	53	668		23
Cumulative totals																			
State																			
Year 1953 to date	2664	8	1402	301	1426	58	2049	60	48	11	2159	12	8	174	1431	90	4484		501
Same period 1952	2707	7	808	148	9013	65	828	20	3	16	795	12	11	140	1613	100	4020		443
5-year median	2998	52	511	—	3893	56	1511	33		32	844	17	28	442	1657	546	4094		416

c = congenital syphilis under 1 year of age.
m = malaria contracted outside of U. S. A. reported by Aberdeen Proving Grounds.
t = tularemia.

SPECIAL CURRENT NOTICES

DOCTOR DRAFT LAW

Today the President signed Public Law 84, 83rd Congress, extending until July 1, 1955 a revised version of the "Doctor Draft Law."

Hearings were held last month in the House of Representatives and the Senate relative to H. R. 4495, 83rd Congress. A slightly different version of this bill was passed by the two legislative bodies thereby necessitating the appointment of a Conference Committee to resolve the differences between the two bills. The measure, as finally passed by the Congress and as signed by the President, will:

(1) Extend the effective date of the "Doctor Draft Law" until July 1, 1955;

(2) Retain the maximum ages specified in existing law: Registration, age 50; Liability for induction, age 51;

(3) Continue in effect the four priorities established by existing law with the following amendments:

(a) All service performed since September 16, 1940 as an officer or as an enlisted man, with certain exceptions which will be outlined later, will be credited as service. At the present time doctors in priorities 1 and 2 only receive credit for service performed "subsequent" to deferment or participation in a Navy V-12 or Army Specialized Training Program during World War II;

(b) The length of service required to qualify for priority 4 for doctors who were deferred or educated at government expense during World War II is reduced from 21 to 17 months. As a result of this provision a substantial number of doctors will be reclassified from priority 2 to priority 4;

(c) Establish the following new periods of service for men recalled to active duty or inducted pursuant to the "Doctor Draft Law":

Previous Service	*New Period of Duty*
9 months or less	24 months
9 to 12 months	21 "
12 to 15 "	18 "
15 to 21 "	15 "

(d) Removes the liability for induction or recall to active duty, except in time of war or national emergency hereafter declared by Congress, for those men in priority 4 who have had 21 months or more of service since September 16, 1940.

(4) Define "active duty" and "active service" to include:

(a) Full-time duty in the active service of the United States since September 16, 1940 in the Army, Navy, Air Force, Marine Corps, Coast Guard or United States Public Health Service, including reserve components;

(b) Time spent during World War II in work of national importance by conscientious objectors;

(c) Service performed before September 2, 1945 in the Armed Forces of countries which were allies of the United States during World War II; and

(d) Service performed as a physician or dentist by United States citizens employed by the Panama Canal Health Department between September 16, 1940 and September 2, 1945.

(5) Exclude from consideration as "active duty" periods spent in a Navy V-12 or Army Specialized Training Program; in a military internship, residency or senior student program; in military service for the sole purpose of undergoing a physical examination or while engaged in active duty for training entered into after June 29, 1953;

(6) Authorize the appointment of medical officers in grades commensurate with their professional education, experience or ability. This section is intended to provide for uniform treatment with respect

to the ranks of all doctors called to active duty irrespective of whether they had previous military service;

(7) Continue until July 1, 1955 the authority to provide the "Special Pay" of $100 per month for doctors in the Armed Forces. This section also extends the class of persons eligible for such pay to include veterinarians;

(8) Authorize the commissioning of non-citizens of the United States as officers in the Armed Forces;

(9) Terminate automatically, upon completion of 12 months or more of service subsequent to September 9, 1950, the reserve commissions of all physicians taken into service by operation of the "Doctor Draft Law." Upon completion of this same service medical reservists recalled to active duty will be given an opportunity to resign their commission. Such persons, whether registrants or reservists, shall not be liable thereafter for recall or reinduction except in time of war or national emergency hereafter declared by the Congress;

(10) Reenact the present provisions of law which permit the deferment of those individuals who are essential to the national health, safety and interest;

(11) Authorize the national, state and local medical advisory committees to the Selective Service System, in addition to their present authority, to make recommendations with reference to the deferment of (a) registrants engaged in residency training, (b) those serving on faculties of medical and certain other schools and (c) those engaged in essential laboratory and clinical research;

(12) Extend until July 1, 1955, the authority of the President to recall medical reservists to active duty involuntarily;

(13) Be retroactive in effect. Those men already in uniform who would have benefited from the new changes in the law will, upon filing an application, be eligible for release from service as soon as possible and in no event later than 90 days after the effective date of the Act (June 29, 1953).

In considering the over-all effect of the new law it should be noted that the major changes involve greater recognition of prior military service. The result is that a particular registrant, by being able to take advantage of the various new provisions, may either (a) become exempt from liability for service, (b) be placed in a priority less vulnerable to immediate call, (c) be subject to a reduced term of service, or (d) effect a severance of military status within 90 days upon application or after the completion of his period of service by being either discharged or permitted to resign. These amendments will remove many of the inequities which now exist.

* * * * *

Baltimore City Medical Society

SECTION ON INTERNAL MEDICINE

Meeting

Medical and Chirurgical Faculty Building

Tuesday, September 29, 1953, 8:30 P.M.

There will be a general discussion, and a cordial invitation is extended to all members who are interested in this Section.

Francis W. Gluck, M.D.
Chairman

Ernest C. Brown, Jr., M.D.
Secretary

CONTENTS—*Continued from Contents Page*

New Building Committee 466
Subcommittee on Finance 466
Building Plans Committee 467
Committee for the Study of Pelvic Cancer 467
Physiotherapy Committee 467
Postgraduate Educational Committee 467
Committee on Public Instruction 469
Committee to Consider the Relationship Between Hospitals and Specialties and the Manner of Payment for Professional Services 470
Committee on Rural Medicine 470
Scientific Speakers Bureau 470
Advisory Committee to the State Health Department 471
Committee to Advise the State Accident Fund 471
Tuberculosis Committee 472
Advisory Committee to the Woman's Auxiliary 472
Board of Trustees of Maryland Medical Service, Inc. 472
Resolutions Committee 423
Creative Arts Show 477
Commercial Exhibitors 478
Officers, Personnel of Committees, etc. 474
Officers and Delegates of Component Medical Societies 475
Autopsy Law 478
Monthly Communicable Disease Report 479

Special Current Notices

Doctor Draft Law 480
Section on Internal Medicine 481
Semiannual Meeting Program for 1953, Outline of 482

Semiannual Meeting

NATIONAL INSTITUTES OF HEALTH, BETHESDA, MONTGOMERY COUNTY

TUESDAY, OCTOBER 6, 1953

BUSINESS SESSIONS—Council, 9:00 A.M.—House of Delegates, 9:30 A.M.

SCIENTIFIC SEMINARS—11:00 A.M.

LUNCHEON—12:45 P.M.

GENERAL MEETING—2:00 P.M. There will be a historical address by Dr. Jacob W. Bird, Sandy Spring, and a scientific paper by Dr. Leonard A. Scheele, Surgeon General, Department of Health, Education and Welfare, U. S. Public Health Service, Washington, D. C.

TOURS—Homes or National Health Institutes, 3:30 P.M.

WOMAN'S AUXILIARY MEETING—9:30 A.M. to 12:00 Noon.

Maryland
STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 2 *September, 1953* NUMBER 9

EDITORIAL

PROPHYLACTIC STERILIZATION OF THE FEMALE

J. TYLER BAKER, M.D.*

Sterilization of the female during the puerperium, has in recent years, reached a rather high incidence on many obstetrical services throughout this state. That this procedure may have played a considerable role in the lowering of the maternal mortality rate in this state cannot be denied. On the other hand, are we being critical enough in evaluating the indications?

In some twenty-nine states there are laws governing compulsory, or involuntary sexual sterilization of the hereditary defectives, clearly delineating the indications. In Maryland there is no specific statute regarding involuntary or voluntary sterilization.

James F. Donnelly and Frank R. Lock (3) in a recent publication have enumerated the major indication for this procedure as follows: hypertensive cardiovascular disease, heart disease, tuberculosis, hereditary diseases, psychiatric disturbances, repeated cesarean sections, multiparity and where multiple pregnancies have caused such gynecologic conditions as prolapse, cystocele, or rectocele and corrective surgery was performed.

In addition they enumerate conditions which are not indications: Rh incompatibility, heart murmurs, difficult delivery, hyperemesis gravidarum, repeated fetal loss, associated operative procedures, lack of desire for children, disability of husband and economic and social factors.

Further they warn of the legal implications involved and advise (1) adequate and specific reason (2) signed recommendation of one or preferably two consultants on the patient's record.

However, there are still indications which some may consider valid which have not been enumerated, and a broader concept or perhaps rule of thumb might be in order. J. L. Baer (1) in a symposium on Medical Legal problems in 1936 discusses indications by stating, in context, that sterilization is permissible in any woman in whom pregnancy will aggravate existing disease which is not amenable to direct cure, undo previous corrective gynecologic procedures or any condition which may jeopardize life. H. E. Bowles (2) feels that sterilization should be accorded its proper place, with due recognition of its importance in prolonging a mother's life in those individuals in whom pregnancy would mean a burden which a frail body could not endure. If multiparity alone is the indication, let it truly be a sufficient number of children. The points, he adds, to be emphasized in the preliminary interview preceding sterilization should include: (1) The gravity of the step the patient is about to take; (2) That the idea of sterilization should originate with her and not have been sold to her by another; (3) The procedure (if successful) is irreversible; (4) The operation is not guaranteed; (5) The patient should have properly evaluated other birth control measures and be fully cognizant of them. Greenhill in discussing Bowles paper expresses himself as follows, "That he sincerely hopes that in the future, sterilization operations will be performed only for legitimate indications and only after proper consultation. In this way, patients who are refused sterilization by conscientious physicians, cannot shop around until they find doctors who will sterilize them, and hospitals where the authorities do not care what is done."

---

* Editorial Board, Maryland State Medical Journal.

To paraphrase a paragraph in a recent editorial note of Dr. Eastman's (4) on therapeutic abortion we might say; "The paramount aim of obstetrics is the preservation of maternal life and health; and sexual sterilization must find its sole justification (if it can be justified) in the degree to which it serves that end. The incidence of sexual sterilization in any given clinic or state, while informative, is not the main issue; the real question is: Do all these operations actually save mothers' lives?"

In most instances of sterilization this question can be answered affirmatively as attested by the lowered mortality rate mentioned in the opening paragraph. Because of the place this procedure has attained as a prophylactic measure, the plea is made to maintain it on a high plane and prevent it from sinking into disrepute through misuse and abuse.

How then can this be done: In a number of hospitals throughout the State measures have been taken; in the majority the means are available. In general this means setting up criteria for indications of this procedure, use of proper forms for granting permission, proper consultation and the establishment or utilization of existing Hospital Review Boards which can review and pass upon the indications for both therapeutic abortions and sexual sterilizations. These should be included in the constitution and by-laws of the Medical Staff and Board of Directors respectively. With this accomplished, abuses which may now be apparent, will be eliminated.

REFERENCES

(1) J. L. Baer, American Journal Surgery, **33:** 513, September, 1936.

(2) H. E. Bowles, Hawaii Medical Journal—November–December, 1943.

(3) James F. Donnelly and Frank R. Lock, Indications for the sterilization of women; North Carolina Medical Journal—January, 1953.

(4) Nicholson J. Eastman, Obstetrical and Gynecological Survey, Vol. VIII: 220, April, 1953.

A CORDIAL INVITATION

for

NOVEMBER 5, 1953

from

Dr. Wetherbee Fort,
President, Baltimore City Medical Society

CLOSED CIRCUIT TV PROGRAM

1211 Cathedral Street, Baltimore, Md.

It is with pleasure that I announce a closed TV demonstration on THURSDAY, NOVEMBER 5, 1953, sponsored jointly by the University of Maryland School of Medicine, the Baltimore City Medical Society, and the Maryland Academy of General Practice. To this I would like to add that all members of the Medical and Chirurgical Faculty of the State of Maryland are cordially invited.

Patterned after a previous telecast held in 1952, the clinical demonstrations will originate in the operating rooms and clinics of the University Hospital and will be carried through the facilities of WBAL-TV by closed circuit to an audience of physicians in both the Gordon Wilson Hall of the University Hospital and Osler Hall of the Medical and Chirurgical Faculty, 1211 Cathedral Street (meeting place of the Baltimore City Medical Society). A double circuit return wire will offer the audience an opportunity to ask direct questions of the clinical demonstrator.

The program will start at 1:00 p.m. It will include a preliminary luncheon at 12:00 noon, to be served at the University Hospital and at Osler Hall—the latter by the Woman's Auxiliary to the Baltimore City Medical Society.

The clinical program will include clinicopathologic conferences, pediatric clinics, an operative clinic, and a gynecologic clinic, with several additions. These presentations will be given by members of the clinical staffs of the University of Maryland and The Johns Hopkins University Schools of Medicine. At this writing we are happy to announce that definite financial sponsorship has been given by the Read Drug and Chemical Company, for which the Staffs of the Medical Schools and the Baltimore City Medical Society are deeply grateful.

As I mentioned above, the telecast held in 1952, and sponsored by the Maryland Academy of General Practice, was a huge success. There is no reason whatsoever why this meeting on November 5 should not be equally so, but it needs your support. There is nothing more discouraging than to undertake a meeting requiring so much planning and work and yet have but a small attendance. SO, MARK THIS DATE ON YOUR CALENDAR NOW AND JOIN US FOR THE FULL MEETING, LUNCHEON INCLUDED, ON NOVEMBER 5, 1953.

Scientific Papers

THE PROTEAN CLINICAL FEATURES OF LEPTOSPIROSIS[1, 2]

THEODORE E. WOODWARD, M.D.[3] AND JOHN A. HIGHTOWER, M.D.

I. Introduction

Weil (1) in 1886, vividly described several human cases of leptospirosis. The classic disease, since the year of his observations, is known as Weil's disease and his description of icterus, fever, hemorrhagic tendency, renal, hepatic and vascular failure with a high fatality serve as a basis for present day reference. Years later, in 1915, Inada (2) identified the causative microbe as a spirochete which was subsequently named a leptospira by Noguchi (3).

Modern bacteriological research methods have complicated the picture through the identification and differentiation of many strains of leptospira shown to infect man. Unlike the classic entity, laid down by Weil, leptospiral infections now compose a multiplicity of separate diseases whose etiological, epidemiological and clinical features vary considerably. The pattern of events as described by Weil is reenacted on wards throughout the world today but emphasis must now shift to the great diversity of the clinical manifestations if we are to suspect and identify the disease.

The present paper will describe the variable clinical manifestations of the human varieties of leptospirosis known to be present in North America.

II. Common North American Types

Following the lead of Australian, European and oriental investigators, human cases of *L. icterohemorrhagica*, *canicola* and *pomona* have been identified in the United States (4, 5). Recently recognized in this country is Indonesian leptospiral infection (*L. bataviae*) (6) capable of causing diseases as severe as the classical Weil's type. At Fort Bragg *L. autumnalis* has been isolated from soldiers who contracted the previously unidentified disease of pretibial fever (7).

The application of modern methods in the investigation of a recent human outbreak of leptospirosis in Puerto Rico has extended the knowledge of the disease on this island (8, 9). In addition to *L. icterohemorrhagica* known to be a cause of human disease, five additional types have been isolated and identified during studies of an epidemic in 1950–1952 (8, 9).

III. Clinical Description

Classical Weil's Disease (*L. icterohemorrhagica*). After an incubation period of about eight days, the disease characteristically begins with a rigor and fever. The pyrexia of the classical case continues between 102° to 104° F. for about eight days and falls by rapid lysis. Sudden toxemia, weakness, intense unrelenting headache and myalgic pains of the legs, back, neck and abdominal muscles appear during the early days. The extreme muscle tenderness is a characteristic clinical feature. Arthritic pains may be intense. Gastro-intestinal unrest manifested by nausea, vomiting and diarrhea are

---

[1] Presented by Dr. T. E. Woodward at the One Hundred and Fifty-fifth Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, on Tuesday morning, April 28, 1953, in Osler Hall.

[2] This paper presented in part at the New York Academy of Medicine on January 21, 1953.

[3] Associate Professor of Medicine, University of Maryland School of Medicine.

noted frequently. A confused state of mentality may occur earlier in this disease than in other common infectious diseases.

A tendency to hemorrhage may occur during the first week of illness with gastrointestinal bleeding or hemorrhagic diathesis of the skin, conjunctivae and mucous membranes. Hyperemia and pericorneal injection of the conjunctival vessels is characteristic quite early in the illness and is often pathognomonic of leptospirosis. The conjunctival reaction is usually without secretion and may persist for several days. Not uncommon as eye manifestations are iritis, iridocyclitis and uveitis. These complications which occur usually in convalescence have a reasonably favorable prognosis. An exanthem similar in some respects to scarletina or German measles is not uncommon and occasionally the lesions may assume a petechial character.

The circulatory status may be likened to the rickettsioses with respect to hypotension and peripheral vascular weakness often of shocklike degree.

Jaundice, when it occurs, appears usually at the end of the first week of illness simultaneously with the defervescence. It may intensify rapidly and persist for a month or more. Fatalities occur among the jaundiced but the intensity of icterus is not necessarily of prognostic significance. Concurrent with the appearance of icterus is the development of hepatomegaly. Splenomegaly cannot be considered a characteristic feature.

The renal, in addition to the hepatic and circulatory manifestations, constitute by far the most helpful prognostic signs. Albuminuria is consistently present in the severely ill. Oliguria, and ultimately anuria, mark the serious cases and fatality may result from the renal involvement. Circulatory failure and hypotension certainly accentuate the azotemia by reducing glomerular filtration. A sudden diuresis may be considered a favorable omen and fortunately after recovery, permanent renal damage is uncommon. The hepato-renal manifestations occur most frequently during the second week of disease after the temperature has reached normal levels.

Not infrequently the neurological manifestations may dominate the clinical picture. In addition to cephalgia, meningitic symptoms frequently appear. Meningism may be extreme, spinal fluid pressure is often increased and a pleocytosis, composed principally of lymphocytes commonly encountered. The meningitis usually subsides uneventfully although troublesome neuritis may ensue.

Leukocytosis and a hypochromic anemia represent the more usual alterations of the hematological picture.

Death occurs in approximately thirty per cent of the jaundiced or in patients classified as severely ill. Occasionally death may ensue during the early stages of the disease as a result of vascular collapse or hemorrhage from the gastrointestinal tract. Usually the patient succumbs in the second week of illness from uremia. The controlling features, therefore, are the stability of the renal, hepatic and vascular systems.

Mild Case (L. icterohemorrhagica)

Illness in the non-icteric case is characteristically milder and invariably terminates favorably. The course of fever is approximately 5–7 days, headache and myalgic signs are present but less intense than in the classical form. Hemorrhage from the intestine, mucous membranes and skin are much less common in the milder case and congestion of the conjunctivae remains a very characteristic sign particularly during the early days of illness. As a rule, when the temperature reaches normal levels, the usual signs of toxemia rapidly abate. Furthermore, the renal and vascular complications do not occur. Conversely, the meningeal features of leptospirosis may accompany the mild case and occasionally run a protracted but benign course.

A variable clinical course is seen, therefore, in patients infected with *L. icterohemorrhagica* and it is possible that fifty per cent or more of the cases of this category may be of the mild type. Fatalities in the jaundiced are approximately thirty per cent and are caused by hemorrhage, circulatory or renal failure. Leptospiral meningitis and eye complications such as iritis or optic neuritis are encountered in mild as well as in severely ill cases.

L. canicola

Leptospiral infections contracted from the dog are essentially similar to the classical Weil's type. Jaundice is very infrequent and meningeal symptoms as well as ocular signs occur (10).

L. pomona

The agent of swineherd's disease, first identified in Pomona, Australia, was given its name of *L. pomona* by Derrick (11) in 1942. The clinical manifestations resemble the mild form of Weil's disease with pyrexia of about seven days and a very low incidence of icterus and death. One of the frequent findings of human *L. pomona* infections is the high incidence of aseptic type meningitis.

In this country Schaeffer (12) has reported the clinical findings among a group of children and young adults who contracted the disease following bathing in a local swimming hole in Alabama. Among twenty-six patients, fever, chills, headache, meningismus and pain in the back were uniformly encountered. Arthralgia and myalgic pains were found in a high percentage whereas nausea, vomiting, constipation and diarrhea were less frequent. Less than one-half of the patients complained of photophobia or showed signs of conjunctival irritation. None were jaundiced or showed signs of hepatic or renal involvement. A noteworthy finding in this well studied series was the presence of signs of aseptic meningitis in six of the twenty-six patients who demonstrated a pleocytosis of lymphocytes and increased intracranial pressure. Beeson and others (13, 14) have likewise incriminated leptospirosis as a cause of approximately ten per cent of those illnesses presenting as benign serous-type meningitis. Therefore, leptospirosis must be considered as a possible etiological cause along with lymphocytic choriomeningitis, mumps, herpes, poliomyelitis, coxsackie disease and the various neurotropic encephalitides when spinal fluid containing lymphocytes is present.

L. bataviae

The Indonesian form of Weil's disease has been detected in the United States and Puerto Rico (6). The clinical features are similar to classical leptospirosis of the icterohemorrhagic type (10). The variability between mild and severe cases, incidence of jaundice, renal and vascular complications and death are roughly comparable.

L. autumnalis (Pre-tibial fever)

Leptospirosis caused by *L. autumnalis* has been recognized in Japan as a mild febrile disease of about seven days duration characterized by slight icterus in a small percentage of cases and a low fatality rate (15). In 1943 Daniels and Grennan (16) described a dengue-like illness of unknown etiology among soldiers at Fort Bragg, North Carolina. The disease, of short duration, was characterized by moderate prostration, fever, splenomegaly and a rash peculiarly localized to the anterior aspects of the legs which gave rise to the name pre-tibial fever. A multiplicity of laboratory tests failed to reveal the nature of this disease. Tatlock (17) in an extensive study adapted the unknown agent thought to be a virus to various experimental animals and also to fertile hens eggs. He successfully reproduced the characteristic signs and symptoms of the Fort Bragg illness in human volunteers.

Recent research investigators of the Army Medical Research Graduate School (7) have successfully identified the causative agent as a leptospira similar immunogenically to *L. autumnalis*. Further studies of the sera from patients with this illness revealed high antibody titers to antigen prepared from this strain.

IV. ADDITIONAL PROTEAN FEATURES

Occasionally a febrile course of four to six days duration with a saddle-back trend similar to dengue fever is noted. Furthermore, it is not unusual for the temperature to continue in some cases during the early days of the icteric stage, up to the tenth to twelfth day of disease. A febrile relapse with a return of the usual objective and subjective manifestations is not uncommon occurring one to two weeks after the initial defervescence. A localized pneumonitis accompanied by the expectoration of blood-tinged or grossly sanguinous sputum is rarely encountered.

CONCLUSIONS

Human leptospiral infections may masquerade as a multiplicity of separate diseases whose clinical features vary considerably. The diversity of the signs and symptoms range from the mildness observed in clinical grippal infections to the fulminant pattern not infrequently observed in infectious hepatitis. The variability in severity between the mild and severe types, the meningeal manifestations and complications are discussed.

BIBLIOGRAPHY

1. WEIL, A., Ueber eine eigenhumliche, mi mitztumor, icterus und nephritis einhergenheude, acute infectionkrankheit, Deutches. Arch. f. Klin. Med. **39:** 209, 1886.
2. INADA, R., IDO, Y., HOKI, R., KANEKO, R. AND ITO, H., The etiology, mode of infection and specific therapy of Weil's disease (Spirochaetosis Icterohaemorrhagica). J. Exp. Med. **23:** 377, 1916.
3. NOGUCHI, H., *Spirochaeta Icterhaemorrhagicae* in American wild rats and relation to the Japanese and European strain. J. Exp. Med. **25:** 755, 1917.
4. GOCHENOUR, W. S., JR., YAGER, R. H. AND WETMORE, P. W., Antigenic similarity of bovine strains of leptospirae (United States) and *Leptospira pomona*. Proc. Soc. Exp. Biol. and Med. **74:** 199, 1950.
5. ASHE, W. F., PRATT-THOMAS, R. R. AND KUMPE, C. W., Weil's disease: a complete review of American literature and an abstract of the world literature. Medicine **20:** 145–210, 1941.
6. GOCHENOUR, W. S., JR., YAGER, R. E., WETMORE, P. W., EVANS, L. B., BYRNE, R. J., ALEXANDER, A. AND HIGHTOWER, J. A., Indonesian Weil's disease in Puerto Rico and the United States. Fed. Proc. **10:** 408–409, 1951.
7. GOCHENOUR, W. S., JR., SMADEL, J. E., JACKSON, L. B., EVANS, L. B. AND YAGER, R. H., Leptospiral etiology of Fort Bragg fever. In press.
8. GOCHENOUR, W. S., YAGER, R. H. AND BYRNE, R. J., Isolation of leptospira in Puerto Rico. In preparation.
9. HALL, H. E., HIGHTOWER, J. A., DIAZRIVERA, R., BYRNE, R. J., SMADEL, J. E. AND WOODWARD, T. E., Evaluation of antibiotic therapy in human leptospirosis. Ann. Int. Med. **35:** 981, 1951.
10. VANTHIEL, P. H., The leptospiroses. Universitarie pers Ledden, Leiden, 1948.
11. DERRICK, E. H., Leptospira pomona. Med. J. Aust. **1:** 431, 1942.
12. SCHAEFFER, M., Leptospiral meningitis. Investigations of a waterborne epidemic due to *L. pomona*. Abstract Am. Soc. Clin. Invest. April 30, 1951.
13. BEESON, P. B. AND HANKEY, D. D., Leptospiral meningitis. Arch. Int. Med. **89:** 575, 1952.
14. BROOM, J. C., Leptospirosis in England and Wales. Brit. Med. J. **2:** 689, 1951.
15. WALCH-SORGDRAGER, B. Leptospirosis. Bull. Health Org. League of Nations **8:** 143–386, 1939.
16. DANIELS, W. B. AND GRENNAN, H. A., Pretibial fever, an obscure disease. J. A. M. A. **122:** 361, 1943.
17. TATLOCK, H., Studies on a virus from a patient with Fort Bragg fever (pretibial fever). J. Clin. Inv. **26:** 287–297, 1947.

DIAGNOSIS AND TREATMENT OF RINGWORM OF THE SCALP[1]

HARRY M. ROBINSON, JR., M.D.[2]

The first epidemic of the ringworm of the scalp occurred in England in 1822 (1), and in 1843 Gruby (2), discovered one of the causative organisms and named it Microsporum Audouini. Sabouraud succeeded in growing this fungus in pure culture on artificial media in 1894 (3). The Wood light was first used as a diagnostic aid by Margarot and Deveze in 1925 (4). Tinea Capitis has been endemic throughout the United States for many years but in 1944 the number of infected children rose to epidemic proportions. The number of cases reported from Hagerstown, Maryland was great enough to necessitate the intervention of the United States Public Health Service. In recent years, due to the large number of cases in the State of Maryland, it has become necessary for the Baltimore City Health Department and the State Health Department to institute public health measures to prevent the spread of the disease. Many reports have been published regarding the value of various topical remedies in the treatment of ringworm of the scalp, but roentgen ray epilation as originally described by Sabouraud and Noire (5), is still one of the most satisfactory methods of treatment.

Course of the Infection

Extensive studies indicate that infection begins with the deposit of spores at the junction of the hair and the follicular orifice (Figure 1) and the invasion of the hair begins in the portion contained within the follicle (Figure 2). This phenomenon is suggested by the fact that hair extracted from a zone 2 to 3 millimeters outside of the patch which exhibits fluorescence under the Wood light will show fluorescence in that portion contained within the follicle but appear normal above the skin surface (Figure 3). A reservoir of infected material remains within the follicle, and as the hair grows the infection is carried above the surface of the scalp.

Pathology of the Infection

By use of the Hotchkiss-McManus stain, using the technique developed by Kligman and Mescon (6), the characteristic features of the infection of the hair by this ectotrix have been demonstrated. When this stain is used the spore sheath stains brilliant red. The hyphae within the hair are also visible but not so intensely stained. The infection of the hair starts by penetration of the cuticle and the cortex after which an ectotrix sheath of spores is laid down. This action takes place between the cuticle and the cortex of the hair by a fragmentation of the hyphae into arthrospores. The entire root of the hair is involved down to but not including the hair bulb (Figure 4a & 4b).

The infiltration of Microsporum Audouini throughout the hair produces a chemical reaction which involves the hair pigment. When infected hair is examined under the Wood light, a brilliant greenish fluorescence is noticed. The nature of this fluorescent material has been the subject of much investigative work. Robinson, Bereston and Figge (7), have studied an aqueous solution of this material by spectroscopy and the infrared absorption spectrum suggests that this fluorescent material is a small molecule which resembles a peptide.

Cultural studies were conducted to determine the nature of the fluorescence obtained and to reproduce it on artificial media, but all such studies were failures. Growth of fungi was not inhibited on artificial media by the addition of androgens and estrogens. The presence of fluorescence does not mean that the infectious material in the hair is viable. In one of our experiments, we examined hair that had been stored for 5 years in a stoppered tube. The hair retained its fluorescence but failed to produce a growth on artificial media (8 & 9).

---

[1] Presented at the One Hundred and Fifty-fifth Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, on Tuesday morning, April 28, 1953, in Osler Hall.

[2] Associate Professor of Dermatology, University of Maryland School of Medicine.

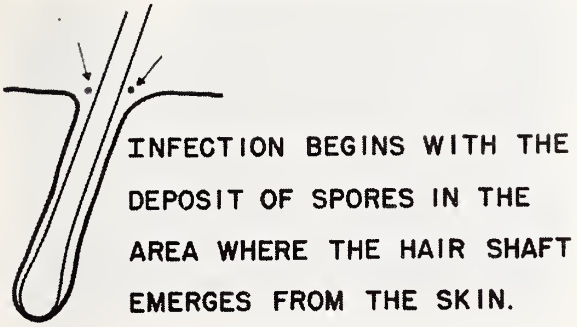

INFECTION BEGINS WITH THE DEPOSIT OF SPORES IN THE AREA WHERE THE HAIR SHAFT EMERGES FROM THE SKIN.

Fig. 1

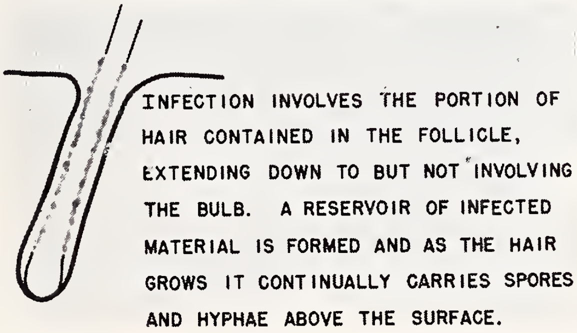

INFECTION INVOLVES THE PORTION OF HAIR CONTAINED IN THE FOLLICLE, EXTENDING DOWN TO BUT NOT INVOLVING THE BULB. A RESERVOIR OF INFECTED MATERIAL IS FORMED AND AS THE HAIR GROWS IT CONTINUALLY CARRIES SPORES AND HYPHAE ABOVE THE SURFACE.

Fig. 2

Diagnosis of Tinea Capitis

The clinical appearance of Tinea Capitis in a well developed case is characteristic (Figure 5). There are one or more well defined areas of partial alopecia. The lesions may be discrete or confluent and the remaining hair is irregular, broken off and sometimes the scalp in the involved area is covered with an adherent dry grayish scale. In some instances where secondary infection has developed, the area is boggy and there are follicular pustules over the surface (Kerion) (Figure 6).

All patients who are suspected of having Tinea Capitis should be examined under the Wood light. The infected areas glow with a brilliant greenish fluorescence when exposed to this illumination in a dark room. The standard Wood light is the most satisfactory piece of equipment to be used for this purpose. The purple X bulb is inexpensive but it is only of value where there is gross infection. Patients with small areas of involvement would not be diagnosed by this method. The mineral light is less expensive than the Wood light, more satisfactory than the purple X bulb but does not approach the efficiency of the larger piece of equipment.

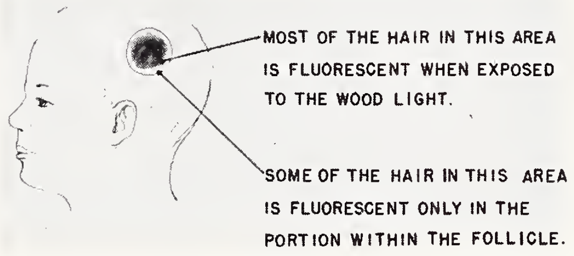

MOST OF THE HAIR IN THIS AREA IS FLUORESCENT WHEN EXPOSED TO THE WOOD LIGHT.
SOME OF THE HAIR IN THIS AREA IS FLUORESCENT ONLY IN THE PORTION WITHIN THE FOLLICLE.

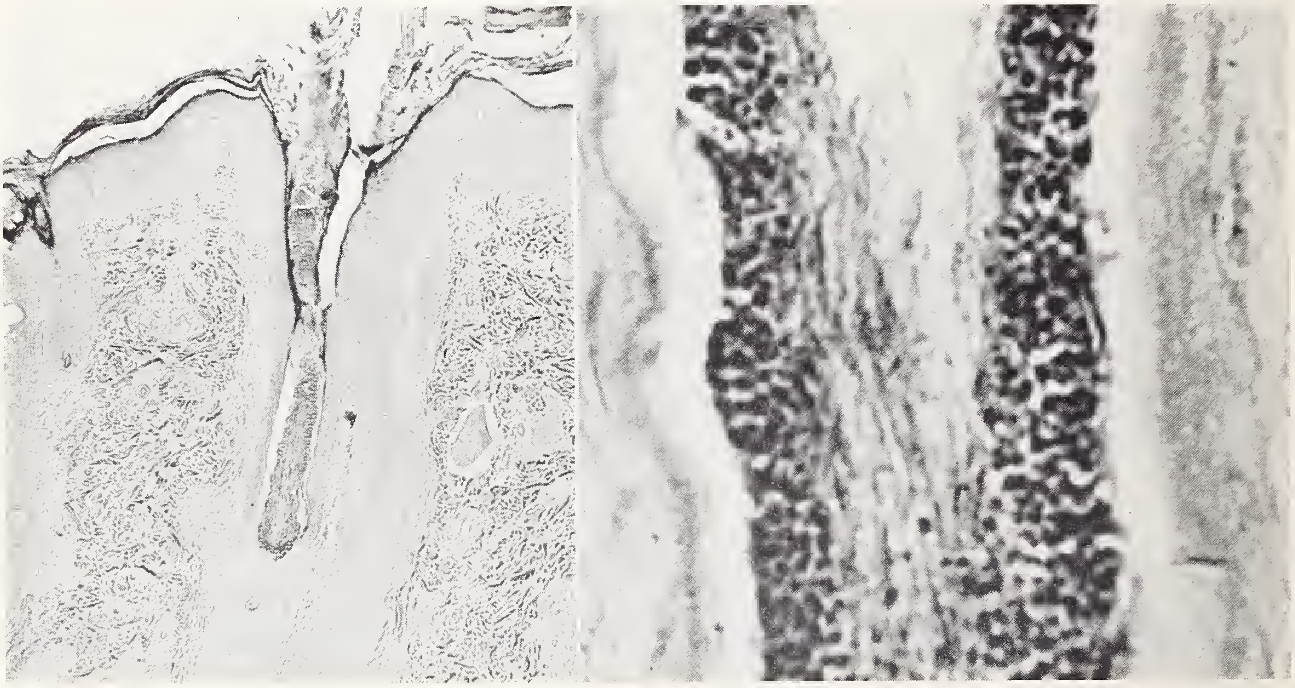
Fig. 3

A simple diagnostic measure which is recommended when the Wood light is not available is the direct microscopic examination method. Hairs are extracted, placed on a standard microscopic slide and covered with a cover slip. A few drops of 10% potassium hydroxide is placed at the side of the cover slip and by capillary attraction surrounds the hair. This material is macerated for 10 to 15 minutes, then the excess of potassium hydroxide is absorbed by a blotter and the slide is examined under the microscope with reduced light to determine the presence of spores and hyphae.

The preceding two measures will demonstrate the presence of infection in the scalp, but the causative organism may only be determined by the use of culture of Sabouraud's media. This is a very important step to take because the type of organism grown on artificial media will determine the nature of the treatment the patient is to receive. If the culture is positive for microsporum Canis (the animal type of fungus), the condition will respond readily to local applications, and the convalescent period will be brief, however, if the organism is Microsporum Audouini we are dealing with a resistant fungus and occasionally such heroic measures as x-ray epilation are necessitated. Sabouraud's media is inexpensive and can be procured from any hospital laboratory at a nominal cost.

TREATMENT OF TINEA CAPITIS

At the present time there is no drug that is specific for the treatment of this infection by local application. Experimental and statistical studies have been conducted with the currently used fungicidal drugs but none of these have been found to be effective in producing a cure in more than 40% of the patients. Decupryl, Salundek, Salinidol, Furaspor, Acrizane, Asterol Dihydrochloride, Cresatin and Spergon are among the products which are commercially available. The reason for the failure of these local applications in the treatment of this disease in 60% or more of the patients, is the fact that the major site of the involvement is in that portion of the hair contained within the follicle where there is a reservoir of spores and hyphae. There is no drug available at the present time which will enter the follicle and destroy the fungus without also damaging the hair papillae. The recommended procedure for the management of the case of Tinea Capitis is as follows:



4b
× 40

4a
× 10

FIG. 4. Histopathology of Microsporon Audouini infectionof the hair.

The entire head is to be shaved or clipped closely and the local application selected is to be rubbed into the involved area twice each day. The head is to be washed once each week and the shaving or clipping of the hair is to be repeated once each week. During the course of treatment the child is to wear a cap made of some washable material all of the time. The cap should only be removed when treatment is being applied. The child should be examined under the Wood light for characteristic fluorescence every two weeks. When the Wood light examinations have been repeatedly negative for a period of two months and cultures from the infected site does not produce a growth on Sabouroud media, a cure has been obtained. If after two months of local application a satisfactory result has not been obtained, the child should be referred for x-ray epilation of the scalp. The entire scalp should be treated using the five points as outlined by Mackee (Figure 7). The so called spot epilation should not be used because in many instances infection may develop outside of the treated areas and this would obviate the possibility of ever using this method of treatment again. Three weeks after the epilating dose of x-ray has been given, hair will fall out of the treated areas. The loose hairs present may be removed by adhesive tape strips. At the end of five weeks after treatment epilation should be complete. The dose necessary to produce this result varies from 325 to 400 R. units. Approximately six weeks after epilation is complete, hair will begin to regrow and in six months the regrowth is actually complete.

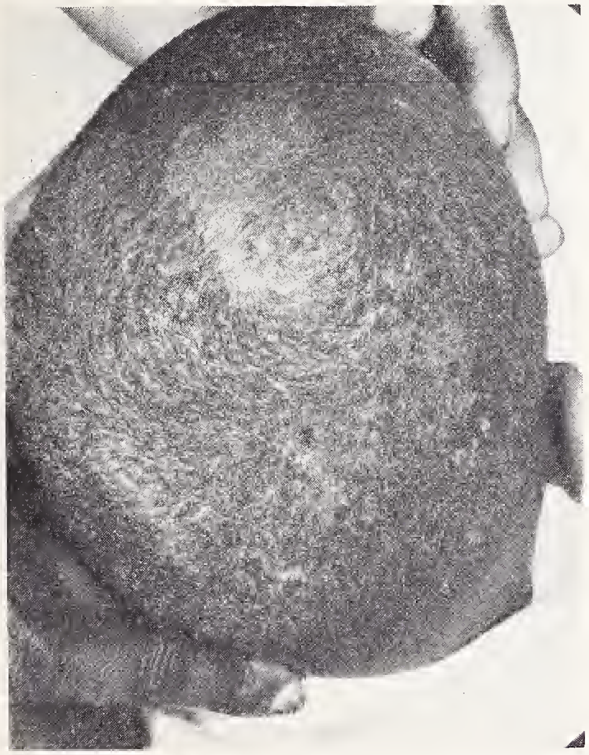


Fig. 5. Tinea Capitis. Note the scaly areas of partial alopecia and the broken-off hair. These areas glow with a greenish fluorescence when exposed to the Wood light in a dark room.

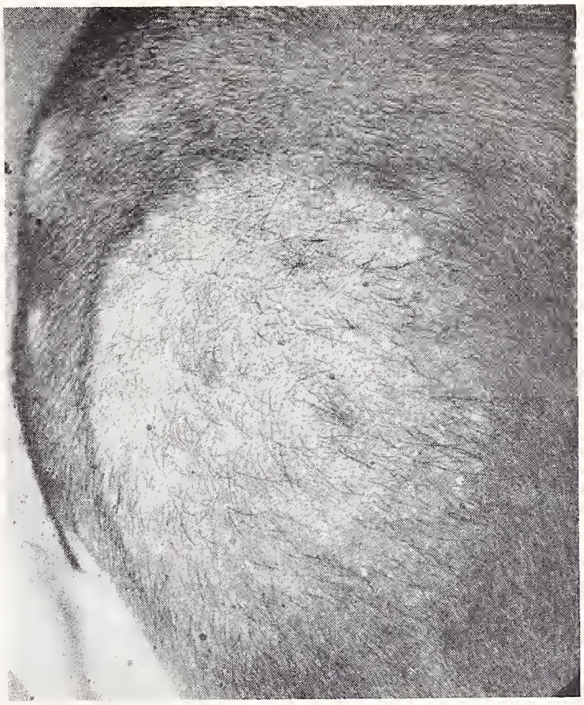


Fig. 6. Tinea Capitis. Note the follicular pustules present. This is a beginning Kerion.

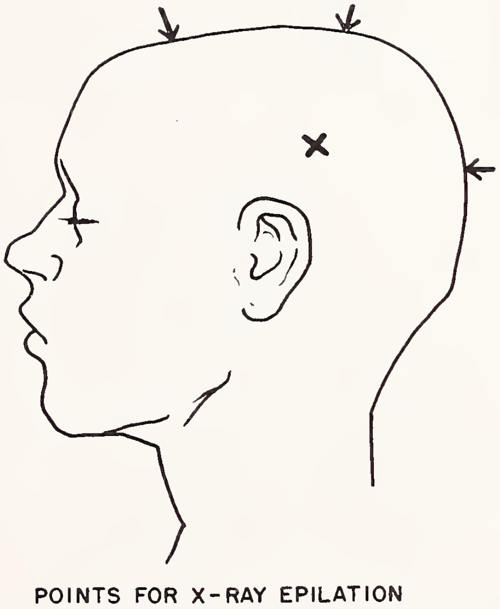


Fig. 7. These are the standard points for roentgen epilation of the scalp of a patient who has tinea capitis.

In the event that secondary pyogenic infection develops in the ringworm areas, x-ray epilation is unnecessary. Treatment may be instituted with the broad spectrum antibiotics by mouth and by local application in order to overcome the pyogenic invaders. When the pyoderma subsides, the fungus infection is usually also under control.

PUBLIC HEALTH MEASURES

All children who have Tinea Capitis should be reported to the local Health Department and follow up measures should be instituted to insure their remaining under treatment until completion of the case. At periodic intervals, school children should be screened by capable personnel using the Wood light. By this means infected children may be segregated and referred to some proper treatment agency. The physician who institutes treatment should insist on careful attention to public health rules. To diminish the spread of the infection, children should be warned not to swap hats with other children. Barber shops should be made to abide by public health rules in the sterilization of all of their equipment and children attending movie houses should either wear hats or place a clean hand towel over the back of the seats. Immediately after having a hair cut, the child should be taken home and given a thorough shampoo to wash out infected hair or spores.

SUMMARY

Tinea Capitis is a benign but highly contagious disease which at the present time has reached epidemic proportions among school children, particularly in the more congested areas of the eastern portion of the United States. Unfortunately, children who have this infection have been made to feel as outcasts in some of the schools, and a mental hazard has been created, not only for the child, but for the parent as well. The physician who is charged with the responsibility for the management of such a patient should carefully and fully explain the nature of the disease to the parents as well as the type of treatment to be used and what may be expected of it. This latter statement is especially necessary in the event that x-ray epilation is to be used. Public health measures are to be enforced to prevent the spread of infection. If this disease is to be among those eliminated the cooperation of all of the members of the medical profession who treat these cases is necessary.

BIBLIOGRAPHY

1. WILKINSON, J. N., Remarks on Cutaneous Diseases. London, J. & A. Churchill, 1822, p. 38.
2. GRUBY, M., Recherches sur la nature, le siege et le developpment du porrigo decalvans au hytealopecie, Compt. rend. Acad. d. sc. **17:** 301, 1842.
3. SABOURAUD, R., Sur une mycose innominee de l'homme, la teigue tendante Speciale de Gruby, Microsporon Audouini, Ann. Inst. Pasteur **8:** 83, 1894.
4. MARGAROT, J., AND DEVEZE, P., Aspect de quelques dermatoses en lumiere ultraparaviolette: Note preliminaire, Bull. sec. d. sc. med. et biol. de Montpellier **6:** 375, 1925.
5. SABOURAUD, R., AND NOIRE, H., Traitement des teignes tondantes par les rayons X a l'Ecole Lailler (Hospital St. Louis) Presse med. **2:** 825, 1904.
6. KLIGMAN, ALBERT M., AND HESCON, HERBERT, Periodic Acid-Schiff Stain for Demonstration of Fungi in Animal Tissue. Journal Bacteriology **60:** 415, 1950.
7. ROBINSON, H. M., JR., BERESTON, E. S. AND FIGGE, F. H. J., The Fluorescence of Microsporon Audouini Infected Hair: Chemical and Spectroscopic Studies. Archives of Dermatology and Syphilology. In Press.
8. ROBINSON, H. M., JR., BERESTON, E. S. AND FIGGE, F. H. J., The Fluorescence of Microsporon Audouini Infected Hair: Cultural Studies. Archives of Dermatology and Syphilology. In Press.
9. ROBINSON, H. M., JR., BERESTON, E. S. AND FIGGE, F. H. J., Inhibition of the Tyrosine-Tyrosinase Reaction by Microsporon Audouini: Preliminary Report. Archives of Dermatology and Syphilology. In Press.

* * * * *

PRIZE ESSAY ON CARDIAC SURGERY

The Trustees of one of America's oldest medical essay competitions, the Caleb Fiske Prize of the Rhode Island Medical Society, announce as the subject for this year's prize dissertation "RECENT ADVANCES IN CARDIAC SURGERY." The dissertation must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of $250 is offered.

For complete information regarding the regulations write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, R. I.

BONE BANK[1]

HENRY G. REEVES, JR., M.D.[2]

Within the past thirteen years the process of preservation of tissue by freezing and other methods has transformed transplantation of homogenous bone from an experimental into an accepted orthopedic procedure. Macewen, in 1878, was the first to use homogenous bone and in 1912 Carrel demonstrated that human tissues preserved in cold storage could be used in surgery.

However, preserved homogenous bone grafting did not gain impetus until 1940 when Inclan first reported his experiences with bone grafts which had been preserved in citrated blood in an ordinary refrigerator. Two years later he reported 52 cases of homogenous grafts with 75% good results. Since that time a number of methods have been described for the preservation of bone. Reynolds and Oliver reported satisfactory results by storing bone in aqueous merthiolate.

The most satisfactory practical method of storing bone was reported by Bush and Garber in 1948. In this method the bone to be stored is scraped of soft tissue and periosteum, cultured, and placed in a sterile jar with a screw top. This jar is then placed in a second sterile jar which is covered by a rubber dam and then placed in a freezing unit which is maintained at −10 to −20 degrees centigrade.

The sources of homogenous bone are varied. The most readily available sources are ribs collected at the time of thoracotomy, tibias and femurs from clean amputations, and portions of the iliac crest during open reductions of hips. The bone of the femur and tibia is thick cortical bone and is useful in the bulk type of graft. Cancellous bone from the iliac crest, tibial and femoral condyles, however, is more valuable since it is rapidly invaded and revascularized. This type of bone is the source of bone chips and bone "meal" which find the widest range of usefulness in homogenous grafting.

Bone may well be collected under sterile conditions from individuals who have died from trauma, cerebral accidents, and coronary disease provided it is collected within four hours after death. Specimens from individuals who have a positive serologic test for syphilis, a history of recent jaundice, malaria, or infection should be avoided. Patients who are known to have, or suspected of having a malignancy, are not candidates for collections. The necessary information concerning the donor and specimen are filed on a card index at the time of collection.

At the time of collection a culture is made of the bone. Originally, cotton swabs were passed over the surface of the bone in culturing but because of the high incidence of contamination it has been decided that a small fragment of bone should be placed in a sterile broth medium for a culture. Cotton is very difficult to sterilize to the degree where all spores are killed and it has a faculty for picking up airborne contaminates.

The bone is then placed in double sealed, sterile jars and the jars are immediately put into a freezing unit. The bone, by being immediately placed in the unit, is frozen with its' own fluid and no additional fluid is added.

The freezing unit is maintained at −10 to −20 degrees C. These temperatures are at best bacteriostatic and not bacteriocidal. After twenty-four hours, if the culture is negative, the bone may be used. At temperatures below −10 degrees C. homogenous bone may be preserved indefinitely. However, in slightly warmer temperatures of −2 to −3 degrees C. bone can be preserved for only two to three weeks. Weaver has used bone in a successful graft over three hundred days after its original collection but the failure rate of grafting is higher in bone preserved for long periods of time.

---

[1] Presented at the One Hundred and Fifty-fifth Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, on Tuesday morning, April 28, 1953, in Osler Hall.

[2] Assistant Resident in Surgery, University Hospital, Baltimore, Maryland.

The temperature in the storage unit is ascertained by a maximum-minimum thermometer. By this thermometer the highest and lowest temperatures are recorded from the last setting of the thermometer.

Cultures should be made of the stored bone at bi-weekly intervals under aseptic conditions. Any positive culture automatically discards the stored bone.

When a case is going to be done which requires homogenous grafting, the bone selected is removed from the freezing unit about four hours before use in order to allow the bone to thaw out. This preparation, however, is not essential and if during the course of an operative procedure a need for homogenous bone arises it may be removed directly from the freezer and used.

After the bone is removed from the sterile jars at the time of operation it may be cut into desired size and shapes depending on the necessity of the procedure.

The uses of refrigerated bone are varied. The field in which it has its greatest usefulness is in spinal fusions, whether it be for tuberculosis, scoliosis, or low back pain. The secret of a successful fusion is dependent on having an abundance of bone and homogenous bone is a readily available source of any desired amount. In addition it shortens the serious operation by avoiding a secondary operation for autogenous bone.

The second field of usefulness is the filling of bone cavities. The cavities created by the removal of benign lesions have to be filled by osteogenic material in order to obliterate the defect. After the curettement of the cavity in osteitis fibrosa cystica, osteoid osteoma, or fibrous dysplasia the defect is often large and homogenous bone chips have been found highly successful in this procedure. Some operators have used bone chips in filling the cavities of chronic osteomyelitis. Wilson reported eight cases which had thorough debridement and filling with bone chips. Seven of the eight cases healed by first intention and have been followed for more than a year.

Homogenous grafts have been used with success in arthrodesis of the wrist, knee, hip, and foot. In ununited fractures homogenous bone is used as thin cortical strips in a barrel stave graft about the host bone. Cancellous bone is then used to fill in the spaces about the ununited fracture to supplement the cortical strips.

The wound infection rate following frozen homogenous grafts is about 2% but is proportionately high in those series where grafts are used in compound wounds and osteomyelitic cavities.

The results following homogenous grafting are comparable to those of autogenous grafting. Every series reported has shown good results in better than 80% of the cases in which it has been used.

The fate of homogenous bone grafts after implantation has now been fairly definitely ascertained. They are well tolerated by living tissues and cause no adverse tissue reaction. Some of the larger homografts heal slower than autogenous bone but the end result is the same. This has been borne out by radioactive P 32 studies.

The process of freezing does not keep the bone cells alive but merely preserves them in a fresh state. In contrast, when autogenous bone is used in grafting, it is doubtful that enough cells live to make any difference in the healing of the graft. The function of homogenous bone is threefold. It serves as a framework or scaffolding to guide the invading elements of the host. It also serves a catalytic function in that its presence promotes an osteogenic reaction, and as a local supply of calcium.

Microscopic examination of sections where homografts have been laid down show the spicules to be dead being surrounded by connective tissue cells with osteogenesis taking place by metaplasis. In due time the bone is absorbed and gradually replaced by living cells.

The chief advantage of homogenous bone is that it is a readily available source of bone in any amount that is necessary. Its use shortens the operative time and decreases the morbidity and shock found in autogenous grafting where a secondary operation is necessary.

CONCLUSIONS

1. The bone bank is a practical addition to any large general hospital.
2. Homogenous grafting is an accepted orthopedic procedure comparable to autogenous grafting.

REFERENCES

1. Bush, L. P., The Use of Homogenous Bone Grafts. A Preliminary Report on the Bone Bank. Journal Bone and Joint Surgery **29:** 620–628, July 1947.
2. Bush and Garber, The Bone Bank. J. A. M. A. Vol. 137. Pg. 588–592, June 1948.
3. Harmon, P. H., Experiences with Use of a Bone Bank in 131 Cases. Permanent Foundation Medical Bulletin. Vol. 8, pp. 97–106, July 1950.
4. Hyatt, G. W., Bone Bank Fundamentals. A Preliminary Report. Lahey Clinic Bulletin, 6–7. Pp. 143–148, July 1949.
5. Hyatt, G. W., Fundamentals in the Use and Preservation of Homogenous Bone. U. S. Armed Forces Medical Journal **1:** 7, July 1950.
6. Inclan, A., The Uses of Preserved Bone Graft in Orthopedic Surgery. Journal Bone and Joint Surgery. Vol. 24, pp. 81–96, 1942.
7. LeCocq, J. F., LeCocq, R. A., Anderson, K. J., Preliminary Report on the Use of Bone Bank Bone. S. G. & O. Vol. 91, pp. 277–280, August 1950.
8. Odell, R. T., Mueller, C. B., and Key, J. A., Effect on Bone Grafts of Radio-active Isotopes of Phosphories. Journal Bone and Joint Surgery. Vol. 33A, April 1951.
9. Reynolds, F. C. and Oliver, D. R., Clinical Evaluation of the Merthiolate Bone Bank. Journal Bone and Joint Surgery. Vol. 31-A, pp. 792–799, October 1949.
10. Stack, W. G. and Dandridge, W. S., Use of Refrigerated Bone on a Large Fracture Service. American Journal of Surgery. **80:** 5, pp. 696–706, December 1950.
11. Weaver, James B., Experiences in the Use of Homogenous (Bone Bank) Bone. Journal Bone & Joint Surgery. Vol. 31-A, pp. 778–792, October 1949.
12. Wilson, P. D., Experiences with a Bone Bank. Annals of Surgery: **26:** pp. 932–945, December 1947.
13. Wilson, P. D., Refrigerated Bone in Surgical Procedures. British Medical Journal. Vol. 1, pp. 1257, May 1950.
14. Wilson, P. D., Follow-up Study of the Use of Refrigerated Homogenous Bone Transplants in Orthopedic Operations. Journal Bone and Joint Surgery. Vol. 33-A, April 1951.

LABORATORY TESTS IN COMMON ENDOCRINE DISORDERS[1]

JOHN G. WISWELL, M.D.[2]

In recent years some physicians who have had long experience in clinical medicine have stated that physical signs are now being discounted and that too much reliance is being placed on x-rays and laboratory tests in making a diagnosis. Such statements may well be true and in this short discussion I shall attempt to point out the demerits as well as the merits of a few laboratory tests which are employed as aids in the diagnosis of endocrine disorders.

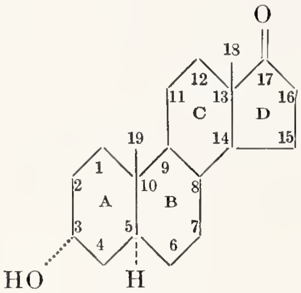
As is the case with normal physical signs, normal values provided by most laboratory tests have a wide range of variation. Therefore the significance of a test may depend upon the interpretation placed upon the result by the doctor. Many tests require a certain standard of chemical or biological technique and so the accuracy of the result may vary with the ability of the technician who performs the analyses. Such factors should always be carefully considered in the evaluation of the result of any laboratory test.

---

[1] Presented at the One Hundred and Fifty-fifth Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, on Tuesday afternoon, April 28, 1953, in Osler Hall.

[2] Assistant Physician, Out-Patient Department, The Johns Hopkins Hospital, and Damon Runyon Fellow, Department of Medicine, The Johns Hopkins University, School of Medicine.

First, let us examine the urinary excretion of 17-ketosteroids. Steroids comprise a number of biochemical compounds such as the bile acids, cardiac aglycones, sapogenins, sex hormones, adrenal cortical hormones and their derivatives. All have the basic cycloperhydrophenanthrene nucleus. A 17-ketosteroid has a ketone group on carbon 17. Estrogens also are 17-ketosteroids but they have a phenolic structure in ring A and are acidic in nature. The compounds with which we are concerned are the neutral 17-ketosteroids. The compound in figure 1 is androsterone, and the other common 17-ketosteroids have different bonds at C_3 and C_5. Those with the OH group projecting beneath the steroid nucleus at C_3 are alpha, those with the OH group projecting outward from the steroid nucleus at C_3 are beta, 17-ketosteroids. We shall discuss later the clinical significance of this difference. Testosterone which has an OH group on C_{17} is not a 17-ketosteroid.



Androsterone

Fig. 1

17-Ketosteroids

The sources of the urinary 17-ketosteroids are the testis and the adrenal cortex. The excretion of these substances therefore depends on the function of these glands and on factors, for the most part unknown, which influence the formation of excretory products from hormones secreted by the glands. For the measurement of 17-ketosteroids, most laboratories request two 24-hour samples of urine, preserved with a few milliliters of concentrated hydrochloric acid or toluene.

In Table 1 are shown values of 17-ketosteroids in the urine per 24 hours which are found in normal individuals of various ages. Below the age of 6, one usually finds less than 1 mg. of 17-ketosteroids. From 6 to puberty the level rises to approximately 5.5. At puberty the secretory products of the testis are added in the male so that these values now reach a higher level than in the female where 17-ketosteroids arise only from the adrenal cortex. Note the wide range of variation found in normal adults (1). After the age of 50 the urinary 17-ketosteroids decline to a lower level again (2).

Table 1

Urinary Excretion of 17-Ketosteroids

(Milligrams per 24 hours)

0–6 years	0–1.0 mg.
6–12 years	0–5.5 mg.
12–20 years	2.0–12.5 mg.
20–40 years (Male)	12.0–16.0 mg. (6.0–25.0)
20–40 years (Female)	7.0–12.0 mg. (3.0–22.0)
50–90 years	3.0–8.0 mg.

Table 2

Decreased Urinary 17-Ketosteroids

1. Malnutrition
2. Adrenal insufficiency
3. Panhypopituitarism
4. Myxedema
5. Hyperthyroidism
6. Liver disease
7. Male castration
8. Hypogonadotropic hypogonadism
9. Anorexia nervosa
10. Anemia, gout, other chronic diseases
11. Diethylstilbestrol, methyl testosterone

There are many conditions in which the urinary excretion of 17-ketosteroids may be decreased below the normal levels (Table 2). In malnutrition in which there is a deficient intake of protein, there may be an impairment in the synthesis of enzymes which are necessary both for the synthesis of hormones and for the degradation of these hormones into 17-ketosteroids. If the 17-ketosteroid excretion is less than 1 mg. in women or less than 3 mg. in men one can suspect adrenal insufficiency. A normal value in a female is certainly good evidence against Addison's disease. One cannot usually distinguish Addison's disease from panhypopituitarism by the urinary excretion of 17-ketosteroids, except in the rare case of panhypopituitarism in a male in whom the 17-ketosteroid excretion approximates zero. Patients with long-standing myxedema may have very low excretions of 17-ketosteroids—as low as those found in Addison's disease (1, 3). In hyperthyroidism the values are only slightly below the normal level (4). The liver is presumed to be the main site of formation of 17-ketosteroids from circulating hormones, and therefore decreased excretions of 17-ketosteroids are found in liver disease (5). Hypogonadism in the male whether due to castration, primary testicular failure, or a decrease in the trophic hormones from the pituitary, may lead to decreased excretion of 17-ketosteroids. On the other hand in such cases the adrenal cortex may compensate by secreting increased amounts of androgens so that the urinary 17-ketosteroids may be entirely normal (4). In anorexia nervosa, as with malnutrition due to other factors, the 17-ketosteroid excretion may be diminished even to levels as low as those found in Addison's disease. Urinary 17-ketosteroids may be somewhat decreased in many chronic diseases such an anemia, gout (6), or by administration of diethylstilbestrol or methyl testosterone (7). The latter compound unlike testosterone is not metabolized to 17-ketosteroids.

There are various disorders in which there is a higher than normal excretion of 17-ketosteroids (Table 3). Of many patients who have hypertension, diabetes, and obesity, some may have hirsutism also and the possibility of the presence of Cushing's syndrome may arise. The urinary 17-ketosteroids may be elevated in Cushing's syndrome, but are frequently normal (8). In the former case, if the β fraction exceeds 50 per cent of the total 17-ketosteroid excretion, the existence of an adrenal tumor is highly probable. If the β fraction is not increased, then adrenal hyperplasia is the more likely diagnosis. The same conditions apply in the adrenogenital syndrome in which the 17-ketosteroid excretion is usually elevated (1). In female pseudohermaphrodites who have congenital adrenal hyperplasia the 17-ketosteroid excretion is increased. Dr. Lawson Wilkins and co-workers at The Johns Hopkins Hospital have shown that administration of 50 mg. cortisone daily for a week will suppress the 17-ketosteroids down to the normal level (9). On the other hand, if an adrenal tumor is present, cortisone either does not affect the 17-ketosteroid excretion or lowers it only slightly. Urinary 17-ketosteroids may be slightly elevated in an occasional instance of simple hirsutism in females who appear to have no other physical abnormalities. Such patients should have further investigation of adrenal and ovarian function. Leydig cell tumors of the testis have been known to produce very high 17-ketosteroid excretion (10). Arrhenoblastomas of the ovary accompanied by signs of virilism may result in increased 17-ketosteroids (1). The effect of stress on the 17-ketosteroid excretion varies. For instance, after an operation the 17-ketosteroids rise to a high normal level for 24–48 hours, fall to a low normal level for the next four or five days, and then return to normal (1). Administration of testosterone or ACTH leads to increased 17-ketosteroid excretion. The former compound is metabolized to 17-ketosteroids (11), the latter stimulates the adrenal to secrete more androgens which are then transformed to 17-ketosteroids (12).

TABLE 3

Increased Urinary 17-Ketosteroids

1. Cushing's syndrome
2. Adrenogenital syndrome
3. Congenital adrenal hyperplasia (females)
4. Hirsutism—females
5. Leydig cell tumor of testis
6. Arrhenoblastoma
7. Stress
8. Testosterone
9. ACTH

In patients who have weakness, fatigue, anorexia and loss of weight, one may suspect adrenal insufficiency. There is a simple procedure by which one can rule out such a diagnosis, namely the water test which was developed at the Mayo Clinic by Robinson, Power, and Kepler (13) (Table 4). This test depends on the inability of patients with adrenal insufficiency to excrete an extra load of water. If the night specimen is less than any day specimen, the patient can be presumed not to have adrenal insufficiency. Otherwise the test is inconclusive—the patient may have adrenal insufficiency, but he may also have such disorders as nephritis, cirrhosis, or gastro-intestinal disturbances with poor absorption of water. In these cases other procedures will be required to determine the patient's adrenal function.

Table 4

Robinson-Power-Kepler Water Test

No fluid after 6 P.M.
Night specimen of urine 10 P.M.–7 A.M.
7 A.M.—20 cc. water/kg. B.W. orally.
Hourly specimens of urine to 12 noon.
Volume of night specimen less than any day specimen, no adrenal insufficiency.

ACTH can be employed to determine adrenal function. There is the four hour test in which one administers 25 mg. ACTH intravenously and measures the fall in eosinophiles four hours later. However, we do not have much faith in this test—too many factors influence the blood eosinophiles and techniques of counting are frequently poor. A better test is shown in Table 5. It is called the 48 hour ACTH test although it takes four days to perform (14). Here the level of 17-ketosteroids is followed as well as the eosinophile count. But again one should not rely on this test alone to make a diagnosis of adrenal insufficiency.

To turn now to the diagnosis of thyroid disorders, the basal metabolic rate has been used for 40 years as a test of thyroid function. When it is performed by a good technician and the patient is in a really basal state, there is no question that the BMR remains an excellent test. However, there are conditions other than Graves' disease in which the BMR is elevated (15) (Table 6). It should also be noted that patients with perforated ear drums or no teeth may give falsely high readings; oxygen may leak out through the ears or around the mouthpiece of the machine. In such instances, there are other tests which may aid in diagnosis. The radioiodine tracer test is based on the ability of the thyroid gland to take up iodine. A dose of radioactive iodine (I^{131}) in aqueous solution which is colorless and tasteless is administered orally, after which the amount of I^{131} excreted in the urine (16) or accumulated by the thyroid (17, 18, 19) is measured (Table 7). One can also estimate the rate at which the radioiodine is collected by the thyroid (20). With these procedures also there is a wide range of variation and the values found in normal persons as compared to those in hypothyroidism or hyperthyroidism may overlap. However, these tests when performed under proper conditions will reflect accurately thyroid function in 90 per cent of cases. A high uptake of radioiodine by the thyroid is found in conditions shown in Table 8 in which the gland or nodules within the gland are avid for iodine (17). In a few instances after cessation of antithyroid drugs which have been

Table 5

48-hour ACTH Test

Day 1—24 hour urine for 17-ketosteroids
Day 2—8 A.M. eosinophile count
10 mg. ACTH i.m. q6h x 8
Day 3—24 hour urine for 17-ketosteroids
8 A.M. eosinophile count
Normal Response—Eosinophiles fall more than 50 per cent, 17-ketosteroids rise 7–10 mg.

Table 6

Elevated Basal Metabolic Rate

1. Hyperthyroidism
2. Acromegaly
3. Pheochromocytoma
4. Hematologic disorders—polycythemia, leukemia, anemia
5. Dyspnea—congestive heart failure, emphysema
6. Diabetes insipidus
7. Paralysis agitans
8. Essential hypertension
9. Fever
10. Anxiety neurosis

administered over a prolonged period of time, the gland is depleted of thyroid hormone, and for a week or two the tracer test may indicate an elevated uptake of radioiodine by the thyroid. Following a thyroidectomy for hyperthyroidism, the surgeon usually leaves a small amount of tissue to maintain euthyroidism. This tissue, however, may be hyperplastic and may therefore accumulate radioiodine at a rapid rate even though the patient is perfectly euthyroid clinically.

TABLE 7

Radioiodine Tracer Test

	URINARY EXCRETION (48 HOURS)	THYROID UPTAKE (24 HOURS)
Normal	40–85%	10–60%
Hyperthyroidism	5–50%	30–90%
Hypothyroidism	60–100%	0–15%

TABLE 8

High Uptake of Radioiodine

1. Graves' disease
2. Adenomatous goiter without hyperthyroidism
3. Iodine deficient goiter
4. After withdrawal of antithyroid drugs
5. After thyroidectomy (rate)

There are a number of instances besides hypothyroidism in which the uptake of radioiodine by the thyroid is decreased (17, 18) (Table 9). One may be able to differentiate between primary myxedema and myxedema due to pituitary failure by administering 12.5 mg. thyroid stimulating hormone (TSH) twice daily for five days and doing a radioiodine tracer test at the beginning and end of this period (21). In pituitary myxedema TSH will stimulate a dormant thyroid gland to take up radioiodine, whereas in primary myxedema in which the gland has completely atrophied, TSH has no effect and the I^{131} uptake remains very low. In such cases as sprue or other diarrheas the absorption of radioiodine may be impaired and the test may therefore not be reliable. The test also may be valueless in patients who have received certain drugs or iodine compounds. Desiccated thyroid depresses the pituitary gland with consequent diminished secretion of TSH which results in impaired ability of the thyroid to take up radioiodine (18, 22). One should wait about four weeks after cessation of desiccated thyroid before the radioiodine tracer test will accurately gauge thyroid function. Antithyroid drugs, ACTH (23) cortisone (24), para-aminosalicylic acid, and butazolidine all inhibit radioiodine uptake by the thyroid, and at least two weeks should elapse after these medications are discontinued before a tracer test is requested. Ingestion of iodine compounds enlarges the body pool of iodine so that the radioiodine is diluted and does not completely go to the thyroid, or the gland may become saturated so that the radioiodine may not be accumulated at all. Such substances which interfere with the tracer test are potassium iodide, iodine absorbed from the skin, cough mixtures and vitamin pills which contain iodides, diodrast, priodax, and lipiodol (17, 18, 19). One should defer a tracer test for at least two weeks and preferably six weeks after these compounds have been stopped. Priodax and lipiodol may be retained in the body and may interfere with the radioiodine tracer test for many months or even years.

TABLE 9

Low Uptake of Radioiodine

1. Hypothyroidism
2. Acute thyroiditis
3. Reidel's struma
4. Cardiac decompensation
5. Addison's disease
6. Interference with absorption
7. Drugs
8. Iodine compounds

Another valuable test for assessing thyroid function is the serum protein-bound iodine (25). In this case the values found in the different clinical states are somewhat more distinct (Table 10). Again the administration of iodine compounds (26, 27), including desiccated thyroid (28) and iodothiouracil (29), interferes with the test and renders falsely high values. TSH given to a patient with pituitary myxedema stimulates a rise in the circulating protein-bound iodine whereas no effect occurs in primary myxedema (21). Mercury interferes with the chemical reaction in the technique used to measure the iodine and therefore the test will produce a low result in patients receiving mercurial diuretics or other mercury compounds. ACTH and cortisone may depress thyroid function and lower the serum PBI (23). The PBI is also decreased in nephrosis, and is apparently lost in the urine with protein although thyroid function is normal (30).

Table 10

Serum Protein-Bound Iodine

Normal values—4–8 micrograms %
Hyperthyroidism—8.5–25 micrograms %
Hypothyroidism—0–3.5 micrograms %
Elevated values—iodides, lipiodol, priodax, diodrast, diiodoquin, desiccated thyroid, TSH, iodothiouracil.
Diminished values—mercury salts, ACTH, cortisone, nephrosis

There is one more clinical disorder which is worth consideration. The exact incidence of pheochromocytoma is unknown, but it probably occurs more commonly than is generally believed because it is not often sought out. In Table 11 are shown the procedures for the histamine and benzodioxane tests which can be performed in the office. For patients with paroxysmal hypertension, the histamine test is indicated (31, 32). Histamine stimulates the adrenal medulla to secrete epinephrine, and administration of it to a person with a pheochromocytoma may reproduce a characteristic episode of hypertension. There should be a greater elevation in blood pressure than that produced by the cold pressor test. If the patient does not have the same symptoms after the injection of histamine as he has in a spontaneous episode, one should doubt the presence of pheochromocytoma even though the blood pressure rises markedly. For the diagnosis of pheochromocytoma in patients who have sustained hypertension this test is of no value and may be dangerous to perform. In such cases the benzodioxane test is useful (33, 34). One should wait a minute or two after venipuncture before injecting the material so that the blood pressure will be perfectly stable. The fall in blood pressure should be measured below the lowest previous level recently observed in the patient, not necessarily the level obtained at the beginning of the test. This test should be employed in all cases of "essential hypertension," and especially where there are minimal pathological changes in the eye grounds and the kidneys, if one is to discover pheochromocytomas. However the test may give a falsely positive result in patients with uremia; and it may be negative in cases of pheochromocytoma so that one may be compelled to explore the abdomen if the clinical picture is suggestive of such a tumor.

Table 11

Pheochromocytoma

Histamine Test—0.025 mg. i.v.
Marked elevation of B.P. in 2 minutes with reproduction of symptoms in previous episodes.
Benzodioxane Test—20 mg. i.v. in 0.2% solution.
Significant fall of B.P. in 2–3 minutes below lowest previous level.

In conclusion, one should seldom if ever rely on a single laboratory test alone to make a diagnosis. On the other hand, to order a battery of tests, the results of which may look well in the patient's record, is not only poor medical practice but costly to the patient as well. The history and clinical findings together with tests judiciously chosen to assess the functions of endocrine glands in particular cases will lead to accurate diagnosis and rational therapy of endocrine disorders.

BIBLIOGRAPHY

1. Mason, H. L., and Engstrom, W. W., The 17-ketosteroids: Their origin, determination and significance. Physiol. Rev. **30:** 321, 1950.
2. Heller, A. L., and Shipley, R. A., Endocrine studies in aging. J. Clin. Endocrinol. **11:** 945, 1951.
3. Statland, H., and Lerman, J., Function of the adrenal

cortex in myxedema, with some observations on pituitary function. J. Clin. Endocrinol. **10:** 1401, 1950.

4. Kenigsberg, S., and McGavack, T. H., The excretion of 17-ketosteroids. II. Values in several endocrine disturbances. J. Clin. Endocrinol. **12:** 1551, 1952.
5. Bongiovanni, A. M., and Eisenmenger, W. J., Adrenal cortical metabolism in chronic liver disease. J. Clin. Endocrinol. **11:** 152, 1951.
6. Shadaksharappa, K., Calloway, N. D., Kyle, R. H., and Keeton, R. W., Excretion of steroidal substances by the adrenal cortex in various diseases. J. Clin. Endocrinol. **11:** 1383, 1951.
7. Reifenstein, E. C., Forbes, A. P., Albright, F., Donaldson, E., and Carroll, E., Effect of methyl testosterone on urinary 17-ketosteroids of adrenal origin, J. Clin. Invest. **24:** 416, 1945.
8. Tompsett, S. L., The neutral steroids of human urine: Quantitative studies in various clinical conditions. J. Clin. Endocrinol. **11:** 61, 1951.
9. Wilkins, L., Lewis, R. A., Klein, R., Gardner, L. I., Crigler, J. F., Rosenberg, E., and Migeon, C. J., Treatment of congenital adrenal hyperplasia with cortisone. J. Clin. Endocrinol. **11:** 1, 1951.
10. Cook, C. D., Gross, R. E., Landing, B. H., and Zygmuntowicz, A. S., Interstitial cell tumor of the testis. Study of a 5-year old boy with pseudo-precocious puberty. J. Clin. Endocrinol. **12:** 725, 1952.
11. Engstrom, W. W., Munson, P. L., Cook, L., and Costa, P. J., Studies on the conversion of testosterone to urinary 17-ketosteroids in normal human males and males with hepatic and other diseases. J. Clin. Endocrinol. **11:** 416, 1951.
12. Venning, E. H., Kazmin, V. E., Ripstein, M., McAlpine, H. T., and Hoffman, M. M., The effect of adrenocorticotropin on the excretion of adrenal metabolites in normal human subjects. J. Clin. Endocrinol. **10:** 583, 1950.
13. Kepler, E. J., Robinson, F. J., and Power, M. H., Diagnostic value of certain studies of renal function in cases of Addison's disease. J.A.M.A. **118:** 1404, 1942.
14. Forsham, P. H., Thorn, G. W., Prunty, F. T. G., and Hills, A. G., Clinical studies with pituitary adrenocorticotropin. J. Clin. Endocrinol. **8:** 15, 1948.
15. Bruger, M., and Hollander, V. P., Extrathyroidal hypermetabolism: Classification and discussion including three illustrative case reports. Ann. Int. Med. **35:** 1260, 1951.
16. Skanse, B., Radioactive iodine in the diagnosis of thyroid disease. Acta Med. Scandinav. Suppl. **235:** 1, 1949.
17. Keating, F. R., Jr., Haines, S. F., Power, M. H., and Williams, M. M. D., The radioiodine-accumulating function of the human thyroid gland as a diagnostic test in clinical medicine. J. Clin. Endocrinol. **10:** 1425, 1950.
18. Werner, S. C., Hamilton, H. B., Leifer, E., and Goodwin, L. D., An appraisal of the radioiodine tracer technic as a clinical procedure in the diagnosis of thyroid disorders. J. Clin. Endocrinol. **10:** 1054, 1950.
19. Freedberg, A. S., Chamovitz, D. L., and Kurland, G. S., Thyroid function in normal and pathological states as revealed by radioactive iodine studies. Metabolism **1:** 26 & 36, 1952.
20. Astwood, E. B., and Stanley, M. M., Use of radioactive iodine in the study of thyroid function in man. West. J. Surg. **55:** 625, 1947.
21. Querido, A., and Stanbury, J. B.: The response of the thyroid gland to thyrotropic hormone as an aid in the differential diagnosis of primary and secondary hypothyroidism. J. Clin. Endocrinol. **10:** 1192, 1950.
22. Johnston, M. W., Squires, A. H., and Farquharson, R. F., The effect of prolonged administration of thyroid. Ann. Int. Med. **35:** 1008, 1951.
23. Hill, S. R., Reiss, R. S., Forsham, P. H., and Thorn, G. W.: The effect of adrenocorticotrophin and cortisone on thyroid function: Thyroid-adrenocortical relationships. J. Clin. Endocrinol. **10:** 1375, 1950.
24. Berson, S. A., and Yalow, R. S., The effect of cortisone on the iodine accumulating function of the thyroid gland in euthyroid subjects. J. Clin. Endocrinol. **12:** 407, 1952.
25. Starr, P., Petit, D. W., Chaney, A. L., Rollman, H., Aiken, J. B., Jamieson, B., and Kling, I., Clinical experience with the blood protein-bound iodine determination as a routine procedure. J. Clin. Endocrinol. **10:** 1237, 1950.
26. Danowski, T. S., Mateer, F., Weigand, F. A., Peters, J. H., and Greenman, J. H., Serum iodine fractions in subjects receiving potassium iodide in small dosage. J. Clin. Endocrinol. **10:** 532, 1950.
27. Rawson, R. W., and Rall, J. E., in Diseases of Metabolism, 3rd ed. Edited by G. G. Duncan: 980, 1952.
28. Danowski, T. S., Huff, S. J., Tarail, R., Wirth, P., Peters, J. H., Mateer, F. M., and Garver, K., Serum protein-bound iodine during ingestion of desiccated thyroid. J. Clin. Endocrinol. **12:** 1572, 1952.
29. Bondy, P. K.: Effect of iodothiouracil on the serum protein-bound iodine. J. Clin. Endocrinol. **11:** 1406, 1951.
30. Recant, L., and Riggs, D. S., Thyroid function in nephrosis. J. Clin. Invest. **31:** 789, 1952.
31. Roth, G. M., and Kvale, W. F., A tentative test for pheochromocytoma. Am. J. Med. Sci. **210:** 653, 1945.
32. Calkins, E., and Howard, J. E., Bilateral familial pheochromocytomata with paroxysmal hypertension: successful surgical removal of tumors in two cases, with discussion of certain diagnostic procedures and physiological considerations. J. Clin. Endocrinol. **7:** 475, 1947.
33. Goldenberg, M., Snyder, C. H., and Aranow, H., New test for hypertension due to circulating epinephrine. J.A.M.A. **135:** 971, 1947.
34. Calkins, E., Dana, G. W., Seed, J. C., and Howard, J. E., On piperidylmethyl-benzodioxane (933F), hypertension, and pheochromocytoma. J. Clin. Endocrinol. **10:** 1, 1950.

THE TREATMENT OF BENIGN UTERINE BLEEDING WITH INTRA-CAVITARY RADIATION[1]

J. MASON HUNDLEY, JR., M.D.,[2] WILLIAM K. DIEHL, M.D.,[3] AND
THEODORE KARDASH, M.D.[4]

The purpose of this paper is to evaluate our results obtained by the treatment of benign uterine bleeding with intra-cavitary radiation.

What Are the Indications for Intra-Cavitary Radiation

1) The patient should be at least 40 years of age; further childbearing not to be considered.
2) Conservative measures, that is, hormonal therapy and curettements having been carried out unsuccessfully on the youngest members of the group.
3) Patients that are poor operative risks due to hypertension, cardiac disease, marked obesity and any debilitating condition that would be an operative procedure hazard.
4) Also patients in or near the menopause with small uterine fibromata, preferably excluding the submucosal type.

What Are the Contraindications for Intra-Cavitary Radiation

1) Early age, under 40 years as a rule.
2) Pelvic inflammatory disease, which may develop parametrial abscess or peritonitis.
3) Ovarian tumors.
4) Large uterine myomata; some radiate such tumors, the size of a 3 months pregnancy. We prefer surgery as complete regression may not take place and bleeding continue; also degeneration may set in, i.e., cystic, hyaline or rarely sarcomatous changes.

Another type of uterine bleeding that has not received sufficient attention is that due to systemic diseases, more commonly seen in aplastic anaemias, essential and secondary thrombocytopenia purpura and constitutional thrombopathy (von Wilebrandt's Disease); the diagnosis of these blood dyscrasias can be accomplished with the aid of a good hematologist. Barnes is of the opinion, from his observations, that an individual with hemorrhagic dyscrasias will not develop hypermenorrhagia without the intermediary of a local pelvic abnormality. His belief was based on intra-abdominal examinations of patients with thrombocytic purpura at time of splenectomy when he found pelvic pathology in the majority of cases. A frequent finding was multiple cysts of the ovary. It is obvious that a close cooperation between the gynecologist and hematologist is necessary.

Technique of Intra-Cavitary Radiation

A careful dilatation and curettage is performed to rule out malignancy. If none is found 100 mg. of radium, in tandem, is inserted into the uterine cavity, the filtration being 1 mm. of platinum and irridium; a dosage of 2000 mg. hrs. is delivered. If malignancy is found multiple applicators of radium are used so that the cavity is well packed; a dosage of 4500 mg. hrs. is delivered. Six to eight weeks later a panhysterectomy is done. We reported, recently, a 5 year survival rate of 84.4 per cent for adenocarcinoma of the body by this combination method of therapy.

The action of the ray, in benign bleeding, is two-fold; the major effect is on the ovary causing follicular elements to undergo regression; whereas the minor action is on the endometrium causing vascular obliteration. Superficial myometrial necrosis may occur.

---

[1] Presented by Dr. J. M. Hundley, Jr., at the One Hundred and Fifty-fifth Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, on Tuesday afternoon, April 28, 1953, in Osler Hall.

[2] Professor of Gynecology, University of Maryland School of Medicine.

[3] Associate Professor of Gynecology, University of Maryland School of Medicine.

[4] Instructor in Gynecology, University of Maryland School of Medicine.

The vast majority of the radiated uteri show very little evidence of gross pathology. Menopausal symptoms are no more severe than those occurring with the physiological process. One would think that surgical oophorectomy, with sudden hormonal imbalance, would be more provocative of a severe climacteric than the rather slow ovarian regression produced by radiation.

An observation found in the literature is to the effect that marked menorrhagia, or flooding, in the climacteric bespeaks increased incidence of corporeal carcinoma developing at a later date. In our experience copious bleeding is frequently seen at the climacteric with subinvoluted, retroverted uteri, resulting from multiple childbearing. In our recent study of body carcinoma we found 64.6 per cent of the patients had borne children. If excessive climacteric bleeding is due to subinvoluted uteri, caused by multiple pregnancies, then we are in accord that malignancy may develop more frequently when preceded by this bleeding manifestation.

An analytical evaluation of 225 patients receiving intra-cavitary radiation for benign uterine bleeding now follows:

For the detailed study 50 patients were discarded due to variations in radiation dosage. The remaining 175 all received the same radium dosage, namely 2000 mg. hrs; these patients have been followed for a sufficient length of time so that the results are of clinical significance.

The social status of the 175 patients showed that 170 were married and only 5 were single. Only 18 were colored although our out-patient clinic is predominantly colored. A partial explanation for this may be due to the great frequency of pelvic inflammatory disease and myomata which necessitates hysterectomy often at an earlier age.

An analysis of the age groups is as follows:

11 patients in the 4th decade.
113 patients in the 5th decade.
48 patients in the 6th decade.

It is interesting to note that 91.9 per cent of the patients treated were between 41 and 60 years of age.

TYPES OF ENDOMETRIA FOUND

The endometria were examined in every case and various patterns were found. It was earlier thought that hyperplasia of the endometria due to a persistent follicle with hyper-estrinism was the most frequent cause of benign, painless uterine bleeding. We now know that although proliferative types, which include hyperplasia are the most frequent, bleeding does occur from a secretory as well as from an atrophic endometria. Polyps were encountered in 9 patients.

Uterine myomata were observed as an associated finding in 37 patients, 92 patients in the group showed evidence of estrogenic activity as is evidenced by the findings of proliferative and hyperplastic endometrium. This is a rather high incidence considering the fact that a large number of these patients were in the post-menopausal group. Of the 51 patients with hyperplasia, 13 were associated with fibromata. Such evidence of possible hyperestrinism is not uncommon.

An analysis of the duration of bleeding (preradiation) is of interest for we know that such a condition may exist for months, the common etiological factors being adenocarcinoma, polyps, and most frequently hyperplasia of the endometrium. Our study showed a wide variation of duration of bleeding from 2 weeks to 18 months. It was either intermittent, or less frequently, continuous in type and as a rule more profuse at the menstrual time and was painless.

A positive diagnosis to rule out malignancy is most essential. Age plays no role in precluding a diagnostic dilatation and curettage. Malignancy may occur at any time. We encountered an adenocarcinoma of the body in a girl 23 years of age when we were sure she had hyperplasia.

HOW EFFECTIVE IS INTRA-CAVITARY RADIATION

This is shown by the duration of bleeding post-radiation. It is here noted that there was immediate cessation in 117 patients; in 7 patients bleeding lasted for 2 weeks; 33 patients had one normal period; 8 had four successive normal periods and one patient menstruated normally for 18 months.

RADIATION FAILURES

In this series of 175 patients there were only 9 failures, 6 due to associated myoma and 4 of these were operated upon. The slight bleeding in one ceased and no operation was required; the remaining patient developed an adenocarcinoma 9 years after the intra-cavitary radium. In the remaining 3, the failures were due in 1 to prolonged stilbestrol therapy, endometrium being markedly proliferative; in another to either adrenal stimulation or rebirth of the follicular system; she required an additional 1200 mg. hrs. of radium 18 months following the initial 2000 mg. hrs. The last patient had 2 subsequent negative curettements with cure and no return of bleeding on a follow-up period of 9 months.

RATE OF RADIATION FAILURES

The incidence of uncorrected failures is 5.1 per cent. If the 6 patients with fibroid disease had been excluded, due to expectant cure being remote, the incidence of failure is 1.7 per cent; this gives an incidence of good end results and cure in 98.3 per cent.

SYMPTOM FREE FOLLOW-UP

70 patients—6 months to 5 years.
64 patients—5 years to 10 years.
32 patients—10 years and over.

MORTALITY AND MORBIDITY RATE

No deaths occurred in this series. One patient developed a left parametrial infection which subsided spontaneously.

A number of prominent gynecologists seem to endorse the belief that radiation increases the incidence of malignancy; they report the appearance of corpus carcinoma developing from 2 years up to 11 years following the initial curettement and radiation. It would seem that the growths detected within two years probably existed at the time of the first investigation. It would be logical to assume that the incidence would be decreased when one considers the atrophic state of the endometrium following radiation.

We are not in accord with the view that radiation tends to increase the incidence of corporeal cancer for we encountered only one malignancy in this series of 225 patients; this developed 9 years following radiation and this incidence is far less than the normal expectancy.

A vital statistical study has been carried out on this series by Dr. Ross Cameron, Chief of the Cancer Division of the Public Health Department, State of Maryland. I quote from his report: "It has been estimated that the normal expectancy of cancer in persons in the above age group is 2.5 per 100 population. In this series there was one case in 225 persons, a rate of 0.44 cases per 100 population, which is significantly less than the normal expectancy."

It seems clear, therefore, that in our patients treated with radium there was no increase in the number of cancer cases above the normal expected rate; on the contrary, the rate was lower by 75 per cent than expected.

Some are of the opinion that the presence of the estrogenic stimulation from the waning radiated ovary plays a role in malignant development of the endometrium. Viable follicular elements do exist after intra-cavitary radiation of 2000 mg. hrs. as we will show later, but would play a minimal role in such development.

Peightal and others believe that corpus carcinoma following surgical ablation of the ovaries is exceedingly rare due to the complete removal of estrogenic stimulation. This theory is not valid since the adrenal gland is another source of estrogenic stimulation.

As we stated above in our series of 175 patients, 117 of these ceased bleeding abruptly after intra-cavitary radiation of 2000 mgh. From this fact one would surmise that complete and prompt disintegration of the follicular apparatus had taken place. From histologic studies of ovaries removed after exposure to 2000 mg. hrs. of radium, fairly normal lutein and follicular elements were observed, the interval between radiation and operation varying from 4 weeks to 18 months. As expected the longer the interval the greater the regressive change. It is difficult to reason that these waning cells could be a prime factor in malignant development as suggested by some observers.

Primordial follicles were observed in the radiated ovary and appeared nearly similar to non-radiated follicles. There is no doubt that complete destruction of the follicle system does not occur promptly after radiation but varying lengths of time are necessary. It is possible that radiation causes sufficient cellular changes to induce hormonal suppression, thus causing cessation of bleeding.

Added evidence that there is not abrupt cessation of follicular activity seems to be demonstrated by the delayed onset of hot flushes, occurring in 4 to 6 weeks, if at all.

We must not over-look the fact that the adrenal cortex is a source of estrogen which comes into play with abeyance of the ovarian source. A recent communication from Dr. Emil Novak is here of especial interest as it concerns the proliferative changes of the endometrium, probably due to estrogenic stimulation arising in the adrenal. He relates a patient with benign uterine bleeding who had a bilateral oophorectomy performed a number of years ago; after a long period of amenorrhea, bleeding returned. She was then seen by Dr. Novak who did a diagnostic dilatation and curettage and found a marked hyperplasia of the endometrium. A laparotomy followed and after a careful search no ovarian tissue was discovered nor was a granulosa cell tumor found. As the uterus was definitely enlarged it was removed. Marked uterine fibrosis, with thickening of the uterine wall and extensive hyperplasia of the endometrium was found.

In Conclusion

We have presented a series of patients that have been successfully treated with intra-cavitary radiation of 2000 mg. hrs. There has been no mortality and only transient sequelae such as leukorrhea, which, in the majority of patients, was minimal.

The uncorrected failures show an incidence of 5.4 per cent; if the 6 patients with fibroid disease are excluded due to expectant cure being remote, the incidence of failure is 1.7 per cent, resulting in a clinical cure in 98.3 per cent of the cases.

We have shown histologically that in spite of the abrupt cessation of bleeding following radiation fairly normal follicular elements are still present. As time advances there is a gradual regression until a corpora albicans is developed. We do not feel that estrogenic effect from these waning follicular elements plays a role in the malignant development. We have encountered one adenocarcinoma arising 9 years after intra-cavitary radiation for bleeding due to a submucous myoma. The reason for the abrupt cessation of bleeding is difficult to explain. It is possible that radiation caused sufficient cellular changes to induce an hormonal imbalance with resulting endometrial suppression, thus causing cessation of bleeding.

Our vital statistical study showed a decrease of expected incidence of corpus carcinoma and we feel that radiation plays no role in later malignant development. Some recent observers feel that benign uterine bleeding may arise on a psychological basis. A most careful elimination of hormonal and organic factors would be necessary before such a deduction would be possible.

Vaginal or abdominal panhysterectomy is preferred by a number of gynecologists on the assumption that ovarian function is preserved and that the increased incidence of corporeal carcinoma is a real factor. From our study we do not feel that these facts warrant the performance of such major surgery.

The sine qua non is the proper selection of patients for this type of therapy. Of the patients treated 91.9 per cent were between 41 and 60 years of age.

The severity of the radiation menopause was not singularly different from the physiological one.

In spite of arguments, pro and con, we are enthusiastic supporters of this type of therapy and feel that it is of the greatest value in selected cases.

ARTHRITIS AND RHEUMATISM

HARRY F. KLINEFELTER, JR., M.D.

This group of disorders comprises an important and increasing cause of disability in our population and constantly drains our social and economic resources. Because these diseases are usually chronic, slowly progressive and undramatic, their victims are infrequently admitted to general hospitals. As a result, the attention of research workers and teachers of medical students has not been focussed on these conditions; consequently, the practicing physician has received little training and instruction in the care of these patients.

Although a feeling of futility and defeat pervades the attitude of many doctors when a patient with "arthritis" is encountered, much can be done to alleviate suffering and improve the person's mental and physical well-being. All that aches is not arthritis and careless use of the word has unnecessarily incapacitated many individuals. While the etiology of most of the rheumatic diseases is unknown and, therefore, cure cannot be achieved, most patients can be so benefitted that they can live useful lives and not become economic liabilities.

The Arthritis and Rheumatism Foundation was started five years ago by a nation-wide group of interested doctors and laymen. It is analogous to national organizations working in other fields of medicine and is financed by voluntary contributions. The purpose of the Foundation is to focus the attention of the public and the medical profession on this wide field of disease states, as yet largely unexplored and unknown.

The National Foundation, with headquarters at 23 West 45th Street, New York City (36), works on a nation-wide basis and through local chapters, of which there are now thirty-five. These chapters are organized in any area, intra- or interstate, where there is sufficient need and interest, and each chapter has its own constitution and governing body. The Maryland Chapter of the Arthritis and Rheumatism Foundation, with headquarters at 1116 Fidelity Building, Baltimore (2), Maryland, was formed in 1949 and has been gradually broadening its activities each year.

The National Foundation performs the following functions:

1. Stimulates organization of new chapters and generally supervises the work of the chapters.
2. Prepares booklets, films, press releases, radio and television programs for education of the public and the patient.
3. Supervises and directs the annual solicitation of funds, which takes place in late November and early December.
4. Awards fellowships to investigators in the basic medical sciences. These doctors may work at any one of the recognized medical centers in the United States.
5. Publishes a monthly "Bulletin on the Rheu-

matic Diseases," from September through May. This is written by authorities in the field of rheumatic disease and keeps the practicing physician informed of the latest developments.

6. Allocates cortisone, donated by one of the drug houses, to the various chapters for use by indigent patients.

The Maryland Chapter of the Arthritis and Rheumatism Foundation performs the following functions:

1. Aids the expansion of the existing arthritis clinics at The Johns Hopkins and University Hospitals.
2. Conducts, through its Medical and Scientific Committee, clinics in those counties whose medical societies have desired this service. Only patients referred by their local physicians are examined and only consultation service is rendered. Such clinics are now held in 17 counties, every three to four months, and will be started in the other counties if their local medical societies so desire.
3. Conducts, through its Medical and Scientific Committee, consultation clinics in other hospitals in the metropolitan area when so requested.
4. Educates the public in the importance of early diagnosis, adequate medical attention and the economic burden of these diseases.
5. Informs the medical profession of the latest developments. The "Bulletin on Rheumatic Diseases" will be mailed without charge to any physician requesting it from the Baltimore office. A joint meeting with the City Medical Society will be held on October 16, 1953, at which time two eminent men in the field will discuss certain aspects of rheumatoid arthritis. A Conference for Industrial Physicians will be held on September 22, 1953, at which there will be three addresses on various aspects of the rheumatic diseases.
6. Offers fellowships to physicians to enable them to get clinical training or do research in these diseases.
7. Encourages the interest and help of women, through the Women's Committee of the Maryland Chapter, whose chairman is Mrs. Noble C. Powell. The women will have many and varied activities, including fund raising, publicity, education, clinic work, administration, home care, occupational therapy and rehabilitation.
8. Organizes Mobile Units, one of which will be in operation in the Baltimore area in the fall. This Unit will be manned by a competent Physiotherapist and will visit indigent patients in their homes.
9. Encourages the rehabilitation of arthritic and rheumatic patients, by stimulating the interest of the medical and nursing professions, industry, and various civic and lay organizations.

Although the major part of the Maryland Chapter's organization and activities has been in Baltimore, some excellent work has been done in the counties. It is hoped and expected that every county will form its own organization, composed of doctors, laymen and women.

The importance of the problem has been recognized by the United States Public Health Service. In 1950, the 81st Congress, through Public Law #692 provided for the establishment of a research institute for the study of Arthritis and Metabolic Diseases. The National Institute of Arthritis and Metabolic Diseases (NIAM) was thus created and twenty-five beds are reserved for studying rheumatic diseases. Patients will not be charged professional fees and will be referred from other institutions or by physicians in private practice.

The NIAM also has extramural programs consisting of research grants, research fellowships and clinical traineeships. Physicians desiring further information concerning these programs should write to the NIAM, Bethesda (Maryland). Dr. Joseph J. Bunim is Chief of the Arthritis Division of the NIAM.

The ARF and the NIAM freely and frequently exchange information and work together to achieve a common goal, namely, better control of the rheumatic diseases.

Component Medical Societies

ALLEGANY-GARRETT COUNTY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

PRESENT TRENDS IN CANCER RESEARCH AND THERAPY[1]

(A summary)

Frank H. J. Figge, Ph.D.[2]

Cancer is one of our most baffling diseases and is attracting more and more attention. Many lines of cancer research are being pursued at present, and hormone imbalance theories are most popular at present. These relate the cause of cancer to hormonal imbalances or maladjustments of the neurohormonal intercommunication systems. The partially successful methods of treatment based on our heroic attempts to modify hormone interrelationships are also very popular at present.

In this connection, three things need to be stressed: (1) Cancer is a disease that should be classified with other constitutional diseases such as obesity, diabetes, and arteriosclerosis, and so forth. These all appear to be related in some way to interacting environmental and genetic factors. (2) The experimental embryologists have shown that these environmental and genetic factors are also responsible for the intercommunication between cells and tissues that initiate and regulate the very early stages of growth differentiation and organization. In these very early stages of development, organization and growth are controlled by simple methods of intercommunication such as diffusion gradients. (3) The process of development of growth and maintenance of organization does not stop at birth but continues with a definite timetable. In the adult, the elaborate and complex neurohormonal intercommunication systems still regulated by internal action of genes interacting with environment continue to maintain the organization of cells and tissues in the body. Wholeness of parts, sex tract changes, and other growth processes are also controlled by this same set of systems.

It is thought that slight defects occurring at any stage of development or defects produced by artificial means or environmental conditions may give rise to a state of stress or overwork on the part of organs or tissues involved in long-term attempts to compensate for such defects. As a result, either the compensating hyperactive endocrine gland or the overworked target organ breaks down and undergoes malignant transformation. After this transformation has occurred, it is doubtful that therapy designed to establish normal or even abnormal hormonal imbalances would cause such malignant cells to return to normal. The impressive but temporary results of treatment of prostatic cancer with orchidectomy and estrogens; and of treatment of breast tumors with testosterone and massive doses of estrogen; or these and other kinds of tumors with adrenalectomies and/or hypophysectomy are encouraging. However, the results indicate only that many or most of the malignant cells can still respond to hormone intercommunication, but ultimately they lose this ability or the cells that cannot respond become predominant, and finally, the most drastic hormone therapy becomes ineffective.

As a result of these theories and recent investigations, we are able to state, however, that such hormones as estrogens are not in themselves carcinogenic. There are now many instances where estrogens have been used to temporarily inhibit or suppress cancer in human subjects and to prevent development of cancer in animals in which hormonal imbalances have been induced artificially. Thus, we may state that it is the hormonal imbalance which has been responsible for the induction of cancer and not the estrogen which was used in massive doses to establish relatively great hormonal imbalances in susceptible animals. Our real hope in this field in the future lies in further research. If these hypotheses are true, we should ultimately develop methods of detecting the subtle hormonal imbalances before they cause malignant transformation. The next step would be to develop methods of correcting the imbalance or maladjustment in the intercommunicating systems before the compensating mechanisms have become over-stimulated or overworked to the point that they transform to malignant cells. Then, our slogan would not be "Detect cancer at an early stage so that it may be more adequately and successfully treated" as it is now, but rather, "Discover cancer-producing maladjusted states, correct them, and prevent cancer before it develops." There are many of us who believe that this great goal can and will be achieved not in the next generation, but in this.

---

[1] Presented at a meeting of the Allegany-Garrett County Medical Society, May 15, 1953.

[2] Professor of Anatomy, University of Maryland School of Medicine.

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

The Chairman of the Program Committee, Doctor Arthur Weinberg, is lining things up for the fall season. The October meeting will be a symposium on arthritis. The November and December meetings are not sufficiently in order to be announced now, except that the symposium type of program will be continued.

The Joint Anesthesia Study Committee of the Baltimore City Medical Society and the Baltimore City Health Department has organized. The results of the organization have not been made available.

FIRST FALL MEETING—BALTIMORE CITY MEDICAL SOCIETY

Wetherbee Fort, M.D., *President*
Lewis P. Gundry, M.D., *Vice-President*
Edward F. Cotter, M.D., *Secretary*
Robert C. Kimberly, M.D., *Treasurer*

Friday, October 16, 1953, 8:30 p.m.

CO-SPONSORSHIP WITH THE MARYLAND CHAPTER OF THE ARTHRITIS AND RHEUMATISM FOUNDATION

8:45 p.m.

Medical Aspects of Rheumatoid Arthritis. Joseph J. Bunim, M.D., Chief, Arthritis and Rheumatism Branch, National Institute of Arthritis and Metabolic Diseases, National Institutes of Health, Bethesda, Maryland; Associate Professor of Medicine, The Johns Hopkins University School of Medicine.

9:30 p.m.

The Restoration of Musculoskeletal Function in Rheumatoid Arthritis. Robert L. Preston, M.D., Assistant Clinical Professor of Orthopedic Surgery, Postgraduate Medical School of the New York University-Bellevue Medical Center, New York City.

10:15 p.m.

Question period.

CALVERT COUNTY MEDICAL SOCIETY

PAGE C. JETT, M.D.

Journal Representative

The new Calvert County Hospital erected in Prince Frederick was dedicated on May 16, 1953. The dedication exercises were quite impressive, being highlighted by a very appropriate talk by Dr. Louis Krause linking the parable of the Good Samaritan with hospital care. Governor Theodore McKeldin, Bishop Noble C. Powell, Reverend Lowell S. Ensor, Mr. Carl F. Wallace, Reverend Louis Albert, and others participated in the program.

The building is a one story, brick and masonry structure and was carefully designed for maximum comfort and service to the patients with a minimum of demand upon the nursing staff. The hospital is rated as a 30-bed hospital but will accommodate about 50 patients, including infants, without crowding. Provision is also made to add six extra beds without cost if they are required, and an additional wing to accommodate 20 beds can be added when needed without increasing service facilities now being provided.

The hospital is modern in every way, having a toilet and bedpan washer adjoining every room and oxygen piped to every patient's room. The operating suite and delivery suite are separated, but each completely equipped, including a new x-ray unit, along with a portable unit. The cost of the hospital was between $780,000 and $800,000.

The grounds are also unusually attractive and are being beautified by the aid of some of the finest horticulturists from the Department of Agriculture who are taking over the project as a hobby.

The cost was met by the use of funds collected from slot machine licensing and matched with Hill-Burton federal funds.

Calvert County now offers the very latest in medical facilities for its residents and physicians.

FREDERICK COUNTY MEDICAL SOCIETY

JESSE S. FIFER, M.D.

Journal Representative

LIBERTYTOWN PHYSICIAN STILL PRACTICING AFTER 60 YEARS

The following article appeared in the "Frederick News and Post:"

On May 3, 1893, a serious purposeful young man emerged from the classic halls of the College of Physicians and Surgeons at Baltimore, a graduate in medicine. He immediately returned to his native Libertytown to practice.

Today, at the age of 85 years, he is deemed Maryland's oldest still active general practitioner.

He is Dr. Ira Washington Beall, affectionately regarded throughout his wide community as purveyor of health, harbinger of comfort and by one and all a family friend.

For sixty years, Dr. Beall has been practicing at Libertytown and still retains a daily schedule, although not quite to the extent of many earlier years gone by. Like others of the old faithful and almost legendary "country doctors" he foresook the saddle and finally the buggy in the early 1900's and ever since 1910 has made and continues to make his calls by automobile. He retains—now—a vivid recollection of his first car. It was second-hand model of a 1907 Ford. Of course, there have been several replacements.

MAINTAINS DAILY SCHEDULE

Hale, hearty and still enthusiastic. Dr. Beall's energy is offset relatively little by his years. His daily office schedule remains unchanged and he still responds to outside calls. His only concession to time is some aversion to night demands unless emergency requires.

Throughout his long career, Dr. Beall has been noted for tenacity to the high ideals and rigid ethics of his profession. Strictly adhering to these principles he lists his patients among all walks of life, white and colored, many times without compensation or reward other than the satisfaction of duty faithfully performed.

That same rugged physical constitution required of a rural doctor has been evidenced by Dr. Beall throughout his long career and carries over until this day. His eyesight is perfect, requiring no glasses and his hearing, Dr. Beall says, is actually above normal. As to personal habits, his regimen has never varied, and Dr. Beall adds: "I've never tasted beer."

IS NATIVE OF LIBERTYTOWN

And now for a little background. Born in Libertytown, a son of Washington and Jane Beall, the doctor received his early education in the public schools. Afterward, he taught for three years at Burkittsville, but his goal delved deeper into the field of human service. He entered the College of Physicians and Surgeons at Baltimore, was a model student, and graduated May 3, 1893, one of a class of 179, the largest in the college's history.

During the preliminary years of his career, Dr. Beall applied himself assiduously toward establishing his practice and he soon became a well-known personality throughout the wide countryside. Then came another outstanding event which was destined to round out his remarkable service and life thus far. That was his marriage on December 22, 1898 to the vivacious Miss Rosa K. Lohr, of Thurmont, daughter of Simon and Frances Anna Lohr, the wedding taking place at St. John's Lutheran Church in Thurmont. Dr. Beall and his bride, a former student at Keymar College at Hagerstown, later to be known as the Washington County Hospital, moved into home and office at Libertytown, where they have since remained. They never saw fit to make a change. They had no children, Dr. Beall's profession remaining his obsession, and the still sprightly Mrs. Beall actively retaining her self-styled characteristic as being "very domestic."

As one can well surmise, Dr. Beall is rich with reminiscence. Wintry storms and summer's torrid heat were faced with the same determination. No call for aid went unanswered. Many a fevered brow was soothed and he ministered, often under great difficulties, when a new life was born. Dr. Beall estimates that he has ushered some 4,000 babies into the world, an average of eighty a year for a period of half a century. In more recent years, he has discontinued obstetrics.

MARRIED NEARLY 55 YEARS

Dr. and Mrs. Beall are inseparable—have been for the nearly fifty-five years they've been married. Except on professional calls, they are never seen

Courtesy of Frederick News and Post

I. W. BEALL, M.D.

apart. Mrs. Beall's emphatic comment on this connubial devotion was simply this: "We're happier than ever!"

In fact, Mrs. Beall is taking the initiative in observing her husband's 60th anniversary in practice. Sunday, May 3, marks that event, and Monday, May 4, is Mrs. Beall's birthday—she coyly refrained from saying which. The two anniversaries, however, will be observed when Mrs. Beall will be hostess at an appropriate dinner party Monday at the Green Parrot in Emmitsburg.

Dr. and Mrs. Beall are both devout Lutherans and frequently attend church in Frederick. There being no Lutheran church in Libertytown, they also enjoy visiting Lutheran churches in various other cities throughout the area.

Dr. Beall has no particular hobby these later years, other than his work and prizes highly his membership in the Maryland State and Frederick County Medical Associations. In this connection it is well to mention that his spouse is just as proud of her domestic inclinations and accomplishments and like "the doctor," Mrs. Beall is the picture of health.

Erect, jaunty and still with a spring in his step, Dr. Beall continues to look to the future. He has no intention of retiring from practice. In the final analysis he tersely enunciated his own philosophy concerning the future in these blunt words:

"I'd rather wear the knees than the seat out of my breeches!"

No more need be said.

ANNOUNCEMENT

THE DOCTOR JULIUS FRIEDENWALD MEMORIAL LECTURE
will be given by

Dr. Richard K. Gilchrist,
Professor of Surgery, University of Illinois, College of Medicine

on

The Principles in Surgical Treatment of Carcinoma of the Colon

Thursday, November 5th, 1953, 8:30 P.M.
At the University of Maryland School of Medicine
Chemical Hall—Main Building
N. E. Cor. Lombard and Greene Sts.
Baltimore

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

VISITORS FROM OVERSEAS

The Library has been visited recently by three foreign librarians: Dr. Elisabeth van der Berg from the University of Leyden, Holland; Mr. Yoshinari Tsuda of the Keio University Medical School in Tokyo, and Mr. Harry Erlam of the University of Otago Medical School, Dunedin, New Zealand.

Under a fellowship program sponsored by the Medical Library Association, these librarians are given an opportunity to study in a library school in this country and to visit various medical libraries to observe methods and techniques.

SUMMER READING

The Library now has on display a sampling of books from the non-medical collection left by Dr. John Ruhräh. Those in the exhibit case at present include choice examples of books on travel, art and archeology, biography, and fiction, and reflect the discriminating and diversified tastes of Dr. Ruhräh. They are all available for borrowing. His fine collection of medical books is of course a valuable part of the Library.

MEDICAL LIBRARY ASSOCIATION

The annual meeting of the Medical Library Association was held this year in Salt Lake City, June 16th–19th. The Librarian, Miss Helen Wheeler, represented this Library at the meeting, and presented her report as Archives Curator of the Association at the business session.

A SELECTED LIST OF PUBLICATIONS RECENTLY ADDED TO THE LIBRARY

American Academy of Ophthalmology and Otolaryngology, Ophthalmic pathology. 1952.
*American Dental Association, Accepted dental remedies. 1953.
*American Pharmaceutical Association, National formulary. 1950.
Anderson, W. A. D., Pathology. 1948.
Association for Research in Nervous and Mental Disease, Psychiatric treatment. 1953.
*Association of American Medical Colleges, Fellowships, funds and prizes. 1949.
*Beck, H. G., Collected writings. 1953.
Behrman, H. T., The scalp in health and disease. 1952.
Bernstine, J. B. and Rakoff, A. E., Vaginal infections, infestations and discharges. 1953.
*Bonola, A., La periartrite della spalla. 1952.
*Bourne, G., Introduction to cardiology. 1949.
Brazier, M. A. B., The electrical activity of the nervous system. 1953.
Brock, R. C., Lung abscess. 1952.
Brown, H. R. et al., Clinical ballistocardiography. 1952.
*Brown, R. C., Reproduction and survival. 1948.
*Buxton, P. A., The louse. 1946.
Clark, A. J., Applied pharmacology. 1952.
Conn, H. F. (ed.), Current therapy. 1953.
Cowdry, E. V., Problems of ageing. 1952.
*Curran, D., Psychological medicine. 1949.
Cutting, W., Annual review of medicine. 1952.
*Deller, F. C., Modern management of gastric and duodenal ulcer. 1948.
De Muylder, C. G., The "neurility" of the kidney. 1952.
*Didusch, W., Collection of urogenital drawings. 1952.
Directory of Medical Specialists, volume 6. 1953.
*Dubos, R. J., Bacterial and mycotic infections of man. 1952.
Duke-Elder, S., Textbook of ophthalmology, volume 5. 1952.
Duncan, G. O., Diseases of metabolism. 1952.
*Ewen, J. H., Mental health. 1947.
Forbus, W. D., Reaction to injury, volume 2. 1952.
Fox, S. A., Ophthalmic plastic surgery. 1952.
*Friedman, M., Functional cardiovascular disease. 1947.
*Friel, A. R., Zinc ions in ear, nose and throat work. 1948.
*Gate, J. and Rousset, J., La lèpre. 1952.

---

* Indicates gifts.

Gifford, S. R., Textbook on ophthalmology by F. H. Adler. 1953.
Gnudi, M. T. and Webster, J. P., The life and times of Gaspare Tagliacozzi. 1950.
*Haas, S. V., Management of celiac disease. 1951.
Hampton, O. P., Wounds of the extremities in military surgery. 1953.
Hardy, J. D., Surgery and the endocrine system. 1952.
*Hern, K. M., Physical treatment of injuries of the brain. 1947.
*Hospital Council of Greater New York, Hospital staff appointments of physicians in New York City. 1951.
Howorth, M. B., A textbook of orthopedics. 1952.
*Jong, H. H. de, Experimental catatonia. 1945.
Keele, K. D., Leonardo Da Vinci on the movement of the heart and blood. 1951.
*Klyne, W., Practical chemistry for medical students. 1946.
*Kopetzky, S. J., Deafness, tinnitus and vertigo. 1948.
*Kyser, F. A., Therapeutics in internal medicine. 1950.
Lewis, G. M., Practical dermatology for medical students and general practitioners. 1952.
*Maryland State Planning Commission, Report of the Committee to review the medical care program. 1953.
Master, A. M., Normal blood pressure and hypertension. 1952.
*Morison, R., Introduction to surgery. 1948.
Moseley, H. F., Textbook of surgery. 1952.
Moss, E. S. and McQuown, A. L., Atlas of medical mycology. 1953.
Munro, D., The treatment of injuries of the nervous system. 1952.
Najjar, V. A., Carbohydrate metabolism. 1952.
National Association for Mental Health, Psychiatric clinics directory. 1952.
*O'Connor, W. A., Psychiatry. 1948.
*Osmond, T. E., Aids to diagnosis and treatment of venereal disease. 1946.
*Palyi, M., Compulsory medical care and the welfare state. 1949.
Patty, F. A., Industrial hygiene and toxicology, volumes 1 and 2. 1948, 1949.
Potter, E. L., Pathology of the fetus and the newborn. 1952.
Ranson, S. W., Anatomy of the nervous system. 1953.
Reynolds, S. R. M., Physiology of the uterus. 1949.
*Rosen, H., Hypnotherapy in clinical psychiatry. 1953.
Rossenda, F. and Strata, A., La spalla paralitica. 1952.
Sachs, E., History and development of neurological surgery. 1952.
Shands, A. R., Jr., Handbook of orthopaedic surgery. 1952.
Smith, H. W., The kidney; structure and function in health and disease. 1951.
*Somervill, T. H., Surgery of the stomach and duodenum. 1948.
Strunk, F. R., Inventory of social and economic research in health. 1953.
Talbott, J. H., Gout and gouty arthritis. 1953.
*Te Linde, R. W., Operative gynecology. 1953.
*Thompson, C. B., Our common neuroses. 1952.
Thorek, P., Diseases of the esophagus. 1952.
*Todd, J. W., Rational medicine. 1949.
*U. S. Children's Bureau, Residential treatment centers for disturbed children. 1953.
U. S. President's Commission on the health needs of the nation, Building America's health, 5 volumes. 1953.
White, J. C., Smithwick, R. H., and Simeone, F. A., The autonomic nervous system. 1952.
*Widdess, J. D. H., Account of the schools of surgery, Royal College of Surgeons, Dublin. 1949.
Wiener, M. et al., Progress in ophthalmology and otolaryngology. 1952.
*Wikler, S. J., Your feet are killing you. 1952.
*Wofinden, R. C., Health services in England. 1948.
World list of scientific periodicals. 1952.
1952 Year book of dentistry.
1952 Year book of dermatology and syphilology.
1952 Year book of drug therapy.
1952 Year book of endocrinology.
1952 Year book of eye, ear, nose and throat.
1952 Year book of neurology, psychiatry and neurosurgery.
1952 Year book of obstetrics and gynecology.
1952 Year book of orthopedics and traumatic surgery.
1952 Year book of pathology.
1952 Year book of pediatrics.
1952 Year book of urology.
*Zondek, B., The antigonadotropic factor with consideration of the anti-hormone problem. 1942.

Health Department

STATE DEPARTMENT OF HEALTH

A Report on the Functioning of the County Medical Care Program

During 1952, the Maryland State Department of Health found it necessary to deal with seven physicians (out of 852 participating) who had misused the County Medical Care Program.

The program has been in operation since 1945. Some misuse has been evidenced since 1947 and attempts have been made to prevent it. In 1952, however, it became clear that more positive action was needed. A brief account of the methods used to detect and prevent such misuse should be of interest to all Maryland physicians. The goal, of course, through suitable educational methods, is its complete elimination.

In order to prevent misuse, it is first necessary to detect it. In the County Medical Care Program, this is done by keeping a complete monthly record of reports on services rendered by each participating physician. At the end of each year, the records of each physician are summarized and analyzed. The records of those doctors who render either an unusual volume of total service or a high intensity of service per patient are segregated for special study. In 1952, the records of 49 of the 852 participating physicians were so studied.

Individual variation from the records of the majority of participating doctors did not necessarily mean misuse of the program. At this stage, the county health officer was notified of the discrepancies between the records of the physician in question and those of other physicians in his area. The health officer was asked to discuss the situation with the doctor, with the assistance of the county medical society or the medical care advisory committee, at his discretion.

The discussion of the problem with the physician in some cases revealed a logical basis for the differences, such as the geographical necessity for many home calls. If the facts indicated true misuse, simple discussion was often followed by a marked improvement.

In some instances, the problem cannot be handled well locally. In this event, the Bureau of Medical Services and Hospitals of the State Department of Health presents the problem to the Committee on Physicians' Services of the State Advisory Council on Medical Care. This committee consists of all those members of the Advisory Council who are physicians in active practice. This group studies the situation in detail and makes a suggestion to the full Advisory Council, which in turn makes its own recommendation to the State Board of Health.

In 1952, the records of eight physicians were brought to the attention of the Committee on Physicians' Services. The end results in these cases were as follows:

> One physician was found to be rendering an extremely high quality of service, commensurate with its cost. Therefore, this case was closed.
>
> Two doctors, when notified in writing of their unusually high frequency of service per patient, stated that they no longer wished to be associated with the program.
>
> One physician was officially dropped from the program because he had misrepresented information on his bills. On the basis of the above, the county medical society terminated his membership.
>
> The remaining four physicians agreed to accept payment for their services at the average monthly cost per patient for all participating doctors in their respective counties. At the Department's request, one of the four in this last group returned $117.00 to the State on the basis of overpayments made, due to faulty bills. This doctor was officially censured in a letter from his county medical society.

From November 1952 through February 1953, actual cash savings to the program were $1,576.47. This represented some bills which were rejected for payment and some which were paid at less than face value, as explained above. There was a further saving which cannot be estimated, because a number of physicians voluntarily reduced their billings when the problem was called to their attention by the county health officers or the Committee on Physicians' Services.

R. H. Riley

Director

State of Maryland Department of Health

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, July 31–August 27, 1953

																			DEATHS
	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County	6	—	2	1	—	—	17	21	15	—	—	2	1	5	19	—	14	—	—
Anne Arundel	—	—	1	3	—	—	1	6	3	1	—	—	—	1	7	1	5	—	—
Howard	—	—	—	—	—	—	—	1	—	—	—	—	—	—	2	—	1	—	—
Harford	1	—	3	1	1	—	—	3	—	1	—	—	—	—	4	—	—	—	—
Carroll	—	—	—	—	—	—	—	—	1	—	—	—	—	1	2	—	2	—	1
Frederick	—	—	1	1	—	—	1	2	—	1	—	—	—	8	—	—	2	—	1
Washington	—	—	—	—	—	—	1	—	1	—	—	—	—	—	5	—	1	—	—
Allegany	—	—	—	1	1	—	—	—	—	—	—	—	—	1	4	—	2	—	—
Garrett	—	—	—	2	—	—	—	—	—	—	—	2	—	—	1	—	—	—	—
Montgomery	—	—	1	2	1	—	23	7	6	2	—	1	—	9	5	—	2	—	2
Pr. George's	—	—	1	—	2	—	5	4	6	—	1	—	—	2	6	—	—	—	1
Calvert	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	c-1	1
Charles	2	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—
Saint Mary's	—	—	—	13	—	—	—	1	—	—	—	—	—	—	3	—	4	—	—
Cecil	—	—	—	1	—	—	—	—	—	2	—	—	—	—	2	—	—	t-1	2
Kent	—	—	—	—	—	—	1	2	—	—	—	—	—	—	1	—	—	—	—
Queen Anne's	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Caroline	—	—	—	—	—	—	4	1	—	—	—	—	—	—	1	—	2	—	1
Talbot	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	2	—	—
Dorchester	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	1	11	—	—
Wicomico	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	1	16	—	—
Worcester	1	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—
Somerset	—	—	—	—	—	—	—	—	—	—	—	—	—	—	4	—	3	—	—
Total Counties	10	0	9	25	5	0	53	49	33	7	2	5	1	28	70	3	67		9
Baltimore City	9	1	4	3	27	0	79	23	29	0	8	1	0	14	95	1	568	c-2	14
State																			
July 31–August 27, 1953	19	1	13	28	32	0	132	72	62	7	10	6	1	42	165	4	635		23
Same period 1952	22	0	15	9	45	1	45	23	33	9	24	3	1	11	213	21	674		32
5-year median	26	4	9	—	61	2	52	57		14	14	4	2	46	211	53	716		26
Cumulative totals																			
State																			
Year 1953 to date	2683	9	1415	329	1458	58	2181	134	108	18	2169	19	9	222	1596	94	5119		524
Same period 1952	2729	7	823	157	9058	66	873	43	36	22	819	15	12	151	1876	121	4694		475
5-year median	3023	56	520	—	3954	58	1563	89		45	858	21	30	528	1868	599	4810		442

c = congenital syphilis under 1 year of age.
m = malaria contracted outside the State.
t = tetanus.

As may be seen the incidence of poliomyelitis is approximately 50% more than the comparable period of last year. The proportion of paralytic cases to non paralytic is about the same as last year. There have been 12 households in which multiple cases have occurred. The efficacy of gamma globulin remains to be evaluated.

BLUE CROSS AND BLUE SHIELD

THE HISTORY OF BLUE CROSS—A NATIONAL HEALTH PLAN

R. H. DABNEY*

There is evidence of the existence of a prepayment health plan on the North American continent as long ago as 1655 in Montreal; similar plans were found in the mining and logging camps of the central Northwest in the 1880's; and there was a plan started in Rockford, Illinois in 1912 that closely resembled our present Blue Cross. However, these isolated early efforts to prepay hospital care were primarily local in nature.

The real prototype of present day Blue Cross came into being in 1929 when a group of schoolteachers in Dallas, Texas realized that they *as individuals* could not save enough to pay hospital bills in an emergency. By a little figuring they found that *as a group* they could easily pay all the hospital bills they were likely to incur. So they entered into an agreement with the Baylor University Hospital whereby, for $3.00 per person per semester, each of the teachers was eligible for twenty-one days of hospital care.

The experiment proved a great success. Other hospitals heard of it and followed suit. But in cities having more than one hospital, overlapping and competitive difficulties arose. It immediately became clear that to be successful, any plan would have to include all the hospitals in the area and permit the patient to choose the one he wished. This was the beginning of Blue Cross.

The idea was tried in California in 1932 and in New Jersey the following year. The latter experiment developed so rapidly that after six months the working capital which has been advanced by a commercial agency was returned and the hospitals took over the management.

From that time to the present, more and more people have come to realize that illness and accidents are unpredictable and that some form of protection against the financial hazards involved is imperative. Membership growth was phenomenal—"Blue Cross" was like a magic phrase. Millions of people were now able to pay their hospital expenses on a personal budgetary basis. The Plan changed many patients from a charity medically indigent status to a medically self-supporting status and at the same time meant more income to the hospitals.

At present, there are eighty-eight Blue Cross Plans with 44,000,000 members nationally protected through the cooperation of over 4,000 member hospitals. The eighty-eight Plans differ in some respects as to rates charged, amount of protection, and methods of operation, but, in general they follow a common pattern. All are operated on a non-profit basis and their collective aim is to bring complete health protection within the range of every pocketbook of every person in the community. Each Plan has local autonomy but must meet the standards set up by the National Blue Cross Commission and the American Hospital Association. Only by meeting and adhering to these standards of organization and operation may a Plan use the symbol of Blue Cross and so qualify for the integrity, honesty and prestige which it represents.

Maryland Hospital Service, Inc., the Blue Cross Plan for Maryland, was founded in 1937 and now has over 860,000 subscribers and 40 member hospitals. Since this enrollment represents approximately only one of every three Marylanders, you will quickly see we still have a large potential. We hope to realize a part of that potential when we are able to launch a program of non-group enrollment. That will be another big chapter in the Blue Cross Story.

---

* Executive Director of Maryland Hospital Service, Inc. and Maryland Medical Service, Inc.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. CHARLES H. WILLIAMS, *Auxiliary Editor*

REVIEW OF CONVENTIONS

The Annual Meeting

MRS. GEORGE H. YEAGER

The Annual Meeting of the Woman's Auxiliary to the Medical and Chirurgical Faculty was held on Wednesday, April 29 at the Sheraton Belvedere and was very well attended. The only formal action taken at the general session was in support of the Bricker amendment. This amendment would prevent government by international treaty from superseding United States law and the Constitution. It would prevent the imposition, from without, of *socialized medicine.*

The meeting was enlivened this year by spontaneous discussion in the form of a state-wide panel on Nurse Recruitment and on Public Relations.

Dr. Louis H. Bauer, President of the American Medical Association, who spoke at the luncheon, which the doctors attended with their wives, had a message for everyone in his description of the broad scope of the Medical Association's efforts in support of continued progress in the hospitals, schools of Medicine, Public Health, legislation, and for the individual patient and his physician, personally.

Following the luncheon, when the doctors returned to the Faculty Building to resume their scientific pursuits Auxiliary members stayed on to see a most beautiful fashion show. It added a decidedly frivolous note to our constant admonition that the doctor's wife must live (and look?) "good Public Relations."

This year for the first time, Maryland was honored by having the President of a neighboring State Auxiliary at our Annual Meeting. Mrs. Preston, of Delaware, was with us for the day, and we enjoyed having her very much indeed. Also, since Mrs. Charles H. Williams, as our President, and Mrs. John G. Ball, as our President-Elect, did attend the Pennsylvania Auxiliary Convention last winter, it begins to look as though a "good neighbor policy" within our National Auxiliary is becoming a reality for us. It is always most encouraging to exchange ideas with the wives of other doctors, nearby, whose ideals and aims are the same as our own.

THE FIRST FUTURE NURSES CONVENTION

Sponsored by Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. D. D. CAPLES

During the year 1952–1953 our State President, Mrs. Charles H. Williams, stressed nurse recruitment as part of our Public Relations Campaign. She further suggested that we have a state-wide convention of "Future Nurses of Maryland." Letters were written to the Superintendents of Public Schools and the Superintendents of Parochial Schools, asking their permission to write to all the High Schools in the State. This was granted, and each school was contacted.

COMMITTEE—FUTURE NURSES CONVENTION, MAY 12, 1953
Left to Right: Mrs. D. D. Caples, Mrs. E. G. Bauersfeld, Mrs. W. K. Mansfield, Mrs. J. G. Ball, Mrs. C. H. Williams, Mrs. T. C. Webster, Mrs. G. H. Yeager.

The Convention was held at the Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore, Maryland, on May 12, 1953. That date is the birthday of Florence Nightingale, the founder of the Nursing Profession. The response to the Convention was more than we had dreamed possible, for more than four hundred girls attended. Mrs. John G. Ball, our new State President, was the presiding officer of the day. The program, with its talks on different aspects of Nursing, a film on Nursing, a parade of student nurses who gave one-minute descriptions of their own hospital, and a light luncheon, was most enjoyable.

First Future Nurses Convention, May 12, 1953, Osler Hall, Medical and Chirurgical Faculty Building

Needless to say, this was a very thrilling day for all Auxiliary members throughout the State who had worked so hard in their own County on the Nurse Recruitment drive.

AMERICAN MEDICAL ASSOCIATION CONVENTION

MRS. CHARLES H. WILLIAMS

The thirtieth Annual Convention of the Woman's Auxiliary to the American Medical Association took place at the Hotel Statler, New York City.

Registration started on Sunday, May 31st. Members of the Hospitality Committee welcomed members and guests. Monday's program consisted of round table discussions of Program, Legislation, Today's Health, and Public Relations. Maryland took part in the panel on Public Relations, having Mrs. George H. Yeager as the Eastern Region Chairman. She cited our Nurse Recruitment scholarships, movie, and the first Future Nurses Convention. The movie and convention were of much interest, being the first in the Country. The idea of the Nurses' Convention was noted by representatives of the "Careers of Nursing" Committee and they requested photographs and data of the Convention for publication in their National magazine.

A tea honoring Mrs. Ralph B. Eusden, President, and Mrs. Leo J. Schaefer, President-Elect, was held that afternoon with the Medical Society of the State of New York and its Auxiliary acting as hosts.

On Tuesday, the formal opening began with the Invocation by His Eminence, Francis Cardinal Spellman, Archbishop of New York. The Archbishop read a prayer of his own from a mythical son fighting in Korea and "our" response. Dr. Peter Murray, President-Elect of New York County Medical Society, gave us greetings as well as Mrs. Harry I. Norton, President of the Woman's Auxiliary, who graciously gave us the key to the city.

A roll call revealed that Maryland had five delegates present, and fifteen total representation, which included our State President and two Past-Presidents. The address of the President of the Auxiliary followed, along with reports of the officers.

At the luncheon (where two Marylanders won door prizes) Dr. Kenneth McFarland, General Motors Public Relations Manager, was the speaker. I do not believe I have ever heard a more fascinating orator. Besides keeping us in laughter, he delivered a wonderful message, the summary of which was the need of Americans for an educated heart. Dr. McFarland felt we could acquire this by (1) an honest sincere respect for the dignity of human personality; (2) a clearer understanding of the difference between happiness and fun; (3) an enthusiasm for the things in which we believe; (4) a belief in an Infinite Power and enduring honor and honesty. Dr. McFarland felt that the only trouble with the Americans was that they stand frozen in their tracks for what they believe—and do nothing!

The afternoon session had the report of the Resolutions Committee. One of interest to me was that we are now supporting parts of the World Health Organization. At this session Maryland's President, Mrs. John G. Ball, gave a wonderful report of the accomplishments of our State. We felt that while we are still very young, we had contributed something concrete and progressive to Auxiliary work.

Wednesday's session had a memorial service to our deceased members. State reports continued and special committee reports ended the morning. At the luncheon "our" Dr. Louis H. Bauer, President of the American Medical Association, addressed the body. He felt that all the "bad apples" in the medical profession should go. Other A.M.A. officials were honored at this function. Miss Margaret N. Wolfe, the Executive Secretary, reported on our National office in Chicago. Unfinished business consisted of the adoption of previously read resolutions, and new business the revisions to the Constitution and By-Laws.

On Thursday, Maryland again took great delight in learning that our State was represented in the new National officers. We were ever so proud to present to Mrs. George H. Yeager, a white orchid as she was installed as the Constitutional Secretary. The new President, Mrs. Leo J. Schaefer, was installed at this session also, and in her address she reminded us of our responsibilities as doctors' wives, and all the problems facing medicine today. Her views were: (1) an informed membership; (2) contacts with community leaders; (3) public service and good public relations. Much emphasis was put on the necessity of our support of the American Medical Education Foundation as the best insurance against socialized medicine.

In the evening the annual dinner was held at the Waldorf Astoria, which started with a social hour. After you attend several of these Conventions you meet people from all over the Nation and look forward to seeing these friends at various functions. The Honorable Ivy B. Priest, Treasurer of the United States, was the guest speaker. She reviewed our National and foreign policies emphasizing the part women now play in world affairs. Each person was presented an orchid flown by air from Puerto Rico. The Puerto Rican theme was carried out throughout the evening, with natives in costume providing the music. Straw hats from the Island served as the table centerpiece.

The seriousness of the business meetings was enlivened by new acquaintances and, of course, the gayety of the evenings in New York.

Marylanders well attended the Convention, and we left with fond feelings for New York City and the American Medical Association.

FOURTH SEMIANNUAL MEETING*

WOMAN'S AUXILIARY TO THE MEDICAL AND CHIRURGICAL FACULTY

WILSON HALL

CLINICAL CENTER (PUBLIC HEALTH INSTITUTE), BETHESDA, MARYLAND

TUESDAY, OCTOBER 6, 1953

9:30 a.m. to 10:00 a.m. Registration.
10:00 a.m. to 10:30 a.m. Board Meeting. State Officers, Committee Chairmen.
10:30 a.m. to 12:00 noon Business Meeting. Mrs. John G. Ball, *President*, Presiding.
  Nurse Recruitment, Mrs. James Kerr.
  New York Convention Report, Mrs. Charles H. Williams.
  Organization, Mrs. Albert Goldstein.
  "Today's Health," Mrs. S. R. Wells.
  Public Relations, Mrs. George H. Yeager.
12:45 p.m. to 1:45 p.m. Luncheon—Cafeteria, Clinical Center.

2:00 p.m. GENERAL MEETING

(All members of the Auxiliary are invited.)

Historical Address: Jacob W. Bird, M.D.
Scientific Speaker: Leonard A. Scheele, M.D.,
  Surgeon General, Department of Health, Education, and Welfare, U. S. Public Health Service, Washington, D. C.
3:30 p.m. to 5:00 p.m. Choice of Tours.
  1. Clinical Center.
  2. Homes of Brookeville.

Tours arranged by the Woman's Auxiliary to the Montgomery County Medical Society, Mrs. E. G. Bauersfeld, *President*, Mrs. William D. Aud, Mrs. J. Marion Bankhead, Mrs. G. V. Hartley, Mrs. Mark V. Ziegler, *Committee*.

---

* This program has been mailed to all members and potential members.

Maryland Academy of General Practice

President—Harold B. Plummer, M.D., Preston
President-Elect—Lauriston L. Keown, M.D., 1938 Linden Ave., Baltimore
Secretary-Treasurer—Nathan E. Needle, M.D., 4215 Park Heights Ave., Baltimore
Vice-Presidents—Bender B. Kneisley, M.D., Hagerstown
Geo. A. Knipp, M.D., 4116 Edmondson Ave., Baltimore
Norman E. Sartorius, Jr., M.D., Pocomoke City
Executive Secretary—Mr. Wm. J. Wiscott, 1818 Ashburton St., Baltimore

FIFTH ANNUAL SCIENTIFIC ASSEMBLY, LORD BALTIMORE HOTEL, OCTOBER 21, 1953

The Program Committee, Dr. Harold B. Plummer, Chairman, and Dr. Walter A. Anderson, Co-Chairman, has arranged another instructive day-long program of post-graduate lectures to be followed by a banquet.

Six outstanding clinicians and teachers will address the Academy—coming from Boston, New York City, Philadelphia, District of Columbia—on problems in medicine, surgery, obstetrics, and endocrinology. They will present timely and practical information on "Late Complications of Diabetes," "Management of Cardiac Failure," "Indication for Pulmonary Resection," "Management of Osteoporosis," "X-ray Diagnosis of Pregnancy," and "The Newer Treatment of Asthma."

The highlight of the annual banquet in the evening will be an address by Alfred P. Haake, Ph.D., author, lecturer and economic consultant to the *General Motors Corporation.* Dr. Haake's topic is "Pills and People."

All members of the Medical and Chirurgical Faculty, and all medical residents and interns in Maryland hospitals are cordially invited to attend this Fifth Annual Scientific Assembly of the Maryland Academy.

The Committee urges that the physicians bring their wives. An interesting program, including luncheon, is being arranged for them. There is no registration fee for the scientific program. The tickets for the banquet may be obtained from Dr. Nathan E. Needle, 4215 Park Heights Avenue, Baltimore 15, at a charge of $7.50 per plate for physicians, and $5.00 for their wives.

PROGRAM

9:00–10:00 A.M. Registration

Morning Session

Moderator—Dr. George A. Knipp

10:00 A.M.—*Late Complications of Diabetes: Prevention and Treatment*
Dr. Alexander Marble
Physician to New England Deaconess Hospital and Associate of Joslin Clinic, Boston.

11:00 A.M.—*The Management of Cardiac Failure*
Dr. Charles C. Wolferth
Emeritus Professor, School of Medicine University of Pennsylvania, Philadelphia.

12:00–1:00 P.M.—Lunch

Afternoon Session I

Moderator—Dr. Norman E. Sartorius, Jr.

1:00 P.M.—*In Memoriam*
Tribute to the late Dr. I. M. Zimmerman by Dr. Benjamin Kader.

1:15 P.M.—*The Indications for Pulmonary Resection*
Dr. Herbert C. Maier
Assistant Professor Thoracic Surgery, Columbia University, Graduate School of Medicine, New York.

2:15 P.M.—*The Management of Osteoporosis*
Dr. Ephraim Shorr
Associate Professor of Medicine, Cornell University, Chief of Endocrine Clinic, New York Hospital, New York.

3:15 P.M.—Recess

Afternoon Session II

Moderator—Dr. Bender B. Kneisley

3:30 P.M.—Presentation of "Physician of the Year" award

3:45 P.M.—*X-ray Diagnosis of Pregnancy*
Dr. Robert H. Barter
Associate Professor of Obstetrics and Gynecology, George Washington University, School of Medicine, Washington, D. C.

4:45 P.M.—*The Newer Treatment of Asthma*
Dr. Charles F. Geshickter
Professor of Pathology, Georgetown University, School of Medicine, Washington, D. C.

6:30 P.M.—Cocktail Hour

7:00 P.M.—Banquet
Dr. Harold B. Plummer, presiding
Principal speaker, Dr. Alfred P. Haake
Music

Note: *Members of the Maryland Academy who attend this assembly will receive credit for 6½ hours of formal post-graduate study.*

ANNUAL BUSINESS MEETING

The Annual Meeting of the Academy will be held in the Lord Baltimore Hotel promptly at 8:15 P.M., Tuesday, October 20th. Business to be transacted includes reports of the officers and committees, formal approval of new constitution and election of officers. All members are urged to be present.

MEMBERS HONORED

The Maryland Academy was particularly honored at the annual meeting of the A.A.G.P. by the election of Dr. E. Irving Baumgartner, *Immediate Past President,* to the Board of Directors of the American Academy for a 3-year term.

The new president of the Medical and Chirurgical Faculty, elected at the annual meeting, is none other than our *Vice President,* Dr. Bender B. Kneisley.

At the same meeting, our former *Vice President,* Dr. E. Paul Knotts, was elected Vice President of the Faculty.

Another *Vice President* of the Academy, Dr. Norman E. Sartorius, Jr., was recently appointed a member of the Board of Medical Examiners of Maryland.

Dr. Nathan E. Needle, *Secretary and Treasurer,* was elected President of the Maryland Academy of Medicine and Surgery at its annual meeting in April. Also, Dr. Needle was recently elected to the Board of Trustees of the Maryland Heart Association.

NEW DIRECTORS

Dr. Merrill M. Cross was appointed to the Board of Directors to the place made vacant by Dr. I. M. Zimmerman's untimely death. Dr. Hugh H. Ward was appointed to fill the unexpired term of Dr. Henry L. Fahrney, resigned.

NEW MEMBERS

Since our spring meeting the following physicians have been elected into *active* membership:

Paul Lubin
320 Patapsco Ave.
Baltimore 25

Louis J. Glass
2730 N. Charles St.
Baltimore 18

Benjamin Miller
2030 Wilkens Ave.
Baltimore 23

Milton Siscovick
1429 W. Fayette St.
Baltimore 23

John P. D'Angelo
4223 Silver Hill Rd., S.E.
Washington, D. C.

Andrew C. Mitchell
228 N. Division,
Salisbury

George B. Patrick
8700 Colesville Rd.,
Silver Spring

John A. Scharffenberg
804 Houston Ave.,
Takoma Park

Melvin J. Jaworski
2711 Eastern Ave.
Baltimore 24

Donald C. MacLaughlin
4508 Edmondson Village
Baltimore 29

Imre Neubauer
936 Patapsco Ave.
Baltimore 25

Aaron Charles Sollod
707 E. Fort Ave.
Baltimore 30

Charles W. Trader
302 Market Street
Pocomoke City, Md.

Frank Anthony Zack
8248 Georgia Ave.,
Silver Spring

Theodor Sattelmaier
Stevensville

The following have become *Associate* members:

Robert Wilson Ard
318 N. Potomac St.,
Hagerstown

Donald F. Bartley
9 N. Hanson Street,
Easton

Willard F. Smith
Rock Hall

Norris Perry
11602 Georgia Ave.,
Silver Spring

George W. Martin, Jr.
Queenstown

Dr. Norman E. Sartorius, Sr., Pocomoke City, was elected to *Emeritus* membership.

A.A.G.P. RECORD

The Maryland Academy as a chartered chapter of the American Academy of General Practitioners, is proud to point to the record of its parent. In six short years the A.A.G.P. has become the recognized spokesman for all general practitioners on a national and local level.

Because of the efforts of the A.A.G.P. the Government and Armed Forces have made special provision for the training of general practitioners and their proper advancement in rank.

Directly and indirectly approximately 50% of the hospitals in the United States have established departments of general practice. Representatives of the Academy are invited to participate in practically every important meeting.

Members of the Academy will be denoted in the forthcoming directory of the American Medical Association with a special symbol. Nearly every hospital, including teaching hospitals, are considering the needs of general practitioners. Post-graduate education has been made available to the general practitioner in his local community at minimum cost.

The honor and prestige of the general practitioner has increased considerably in the last six years.

General practitioners have increasingly been appointed to committees and office in both national and local medical organizations.

MEMBERSHIP REQUIREMENTS

The prerequisites for becoming a member of the Academy are simply that the physician must belong to the Medical and Chirurgical Faculty of Maryland, and must devote the greater part of his time to the general practice of medicine. Those who have been in practice for less than three years may apply for associate membership. Any doctor who has practiced medicine for 30 years or more, or who has attained the age of 70, is eligible to emeritus membership. One of the chief aims of the A.A.G.P. is to maintain post-graduate education. Each member of the Academy must during each 3-year period, report 150 hours of medical study to be eligible for re-election to membership. One hundred of the 150 hours can be made up by attendance of national, state and local medical society scientific meetings and at regular hospital staff clinical meetings. The remaining 50 hours must be for attendance at formal study courses such as are offered as post-graduate courses at various medical schools and approved hospitals, or such as the scientific meetings sponsored several times a year by the Maryland Academy of General Practice. Actually, during a 3-year period, a busy doctor who cannot get away for prolonged post-graduate courses, can receive enough credit by full attendance at these one-day scientific assemblies.

* * * * *

ANNUAL MEETING OF THE AMERICAN HEART ASSOCIATION, 1954

The Annual Meeting of the American Heart Association in 1954 will be held at the Conrad Hilton Hotel in Chicago. The Assembly Panels and the General Assembly will be held on Thursday and Friday, April 1 and 2, and will be followed by a specific scientific program on clinical cardiology on Saturday and Sunday, April 3 and 4, conducted under the auspices of the newly formed Section on Clinical Cardiology of the Scientific Council. These sessions will immediately precede the annual meeting of the American College of Physicians.

Letters to the Editor

Anne Arundel County Medical Society
June 18, 1953
Dr. George H. Yeager, Secretary
Medical and Chirurgical Faculty of the State of Maryland
1211 Cathedral Street
Baltimore 1, Maryland

Dear Doctor Yeager:

At the regular meeting of the Anne Arundel County Medical Society on June 16, 1953, the following resolution was passed:

"Whereas the Anne Arundel County Medical Society recognizes the need of the Medical and Chirurgical Faculty for additional funds to carry on its splendid work,

"Therefore, the Anne Arundel County Medical Society commends the action of the House of Delegates in assessing each member ten dollars for the current year."

Sincerely yours,
/s/ J. Howard Beard, M.D.
Secretary-Treasurer.

Oakland, Maryland
June 19, 1953
Dr. J. Albert Chatard, Treasurer
Medical & Chirurgical Faculty of the State of Md.
1211 Cathedral Street
Baltimore 1, Maryland

Dear Doctor Chatard:

Enclosed find check for special assessment for members of the Faculty.

Early this month I was in New York attending a meeting of the Board of Directors of the American Academy of General Practice as well as the meeting of the American Medical Association. It was very interesting to find that in conversation with others, dues in Maryland, particularly those of the County members, were much lower than in many other states.

It would seem to me the most satisfactory solution would be a dues increase of $15.00 per year.

Very truly yours,
/s/ E. Irving Baumgartner, M.D

* * * * *

WOMAN'S AUXILIARY TO THE BALTIMORE CITY MEDICAL SOCIETY

Mrs. Conrad Acton, Corresponding Secretary

Mrs. E. Roderick Shipley, Chairman of the Program Committee, is arranging the meeting for Wednesday, October 7, 1953. The guest speaker will be announced at a later date.

"Community Service in the Field of Health," is the subject to be developed during the coming year.

The members of the Baltimore City Medical Society are requested to urge their wives to attend this first meeting of the Woman's Auxiliary to the Baltimore City Medical Society.

PLAN TO ATTEND THE SEMIANNUAL MEETING

WHEN THE MEDICAL AND CHIRURGICAL FACULTY WILL CELEBRATE THE FIFTIETH ANNIVERSARY OF THE MONTGOMERY COUNTY MEDICAL SOCIETY

TUESDAY, OCTOBER 6, 1953

NATIONAL INSTITUTES OF HEALTH, BETHESDA, MARYLAND

For further details see your program

Maryland
STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 2 *October, 1953* NUMBER 9

Blue Cross–Blue Shield Enrollment Period for Medical and Chirurgical Faculty Members and Employees During November, 1953

The annual Blue Cross–Blue Shield enrollment period for Medical and Chirurgical Faculty members and their employees will take place during the month of November. During this time, applications will be accepted for new members and for present subscribers desiring a change in type of coverage. The latter part of October you will receive a letter from Blue Cross–Blue Shield presenting information covering the details of enrolling along with explanatory material and application cards.

Blue Cross is designed to pay the hospital bill when a subscriber is hospitalized. Blue Shield is the partner plan of Blue Cross. It provides medical and surgical benefits in the hospital when such care is needed.

Under the Blue Shield Plan, single subscribers whose total income is $3,000 or less, or married subscribers whose total income is $4,000 or less are eligible for full service benefits. If your income exceeds these amounts, your doctor will ask you to pay the difference, if any, between the Blue Shield allowance and his usual fee.

For additional information concerning the advantages of the Blue Shield Plan, please consult the folder which will be sent you by the Blue Cross–Blue Shield Office.

While the majority of Faculty members are probably familiar with the details of Blue Cross, a summary of the main features of the Plan is presented for your convenience.

For subscribers using semi-private rooms, Blue Cross pays the bill in full for the customary hospital services regardless of cost. These services are:

a. Room, meals, special diet.
b. General nursing care.
c. Use of the operating room.
d. Anesthesia given by hospital employee.
e. Standard drugs and medication.
f. Laboratory examination (when necessary part of in-patient care).
g. X-ray examinations.
h. Electrocardiograms.
i. Physiotherapy.
j. Casts and dressings.
k. All other customary hospital services.

Subscribers using private rooms receive a credit of $7.00 a day toward the room charge plus a credit of 75% of the charges for all customary hospital services.

As in the case of Blue Shield all basic information concerning Blue Cross will be contained in folders which will reach you direct from the Blue Cross Office.

Blue Cross–Blue Shield is the nation's largest non-profit health program with over 44,000,000 members in 87 Blue Cross Plans protected through the cooperation of over 4,500 hospitals and with over 23,000,000 Blue Shield subscribers protected through the cooperation of the nation's medical profession.

Continued support of the Blue Cross–Blue Shield Plans is still the best means of enabling citizens of Maryland to pay for their health care on a voluntary basis. The success of Blue Cross–Blue Shield is universally used as a most effective counter-proposal in discussion and debates wherever the need for some enforced health program is advocated. Blue Cross–Blue Shield, operating as they do on a non-profit basis with the cooperation of the hospitals and medical profession has proven to be the most inexpensive method of providing comprehensive benefits to persons who wish to maintain freedom of choice and opportunity in managing all needs pertaining to their health.

* * * * *

DOCTORS IN KOREA TO AID MEDICAL REHABILITATION

The AMA Washington Letter, No. 34

U. S. Armed Forces physicians in Korea will be utilized to help in the rehabilitation of South Korea's medical services, according to a Defense Department directive. The department explained that uncertainties in Korea require retention of American troops, with the usual ratio of doctors. When these physicians can spare the time from their military duties, they will be expected to help in the re-establishment and expansion of medical teaching facilities, hospitals, public health, and "other programs required for the betterment of the health and welfare" of the population. Defense Secretary Wilson, however, emphasizes that the new policy may not be used "to justify the retention of medical personnel in the Far East beyond their established tour of duty nor as authority to staff the required military facilities in that area beyond that necessary to carry out the military medical mission. . . ."

* * * * *

FEDERAL SCHOLARSHIPS

The AMA Washington Letter, No. 34

Defense Department officials are at work again on a proposal to have Congress authorize federal scholarships to *students in medicine*, dentistry, nursing, and several other health fields. Recipients would be required to spend a specific amount of time in military service following completion of their education. The idea has been suggested previously in a number of bills offered in Congress, but so far nothing has come of it.

PRESENTATION OF VOLUME[1] CONTAINING THE WRITINGS OF DR. HARVEY G. BECK[2]

WALTER D. WISE, M.D.[3]

Mr. Chairman, Mrs. Beck, Mrs. Mahan,[4] Ladies and Gentlemen:

In a few minutes you will hear the first Harvey Grant Beck Lecture by Dr. T. S. Danowski, a Lecture generously endowed by Mrs. Beck. (*See pages 530–537.*)

Dr. Beck was born in York County, Pennsylvania on August 15th, 1870 and his life came to an end in Baltimore on October 30th, 1951. He was active to within a few days of the last. He lived a long and most useful life and I believe he enjoyed it fully. He enjoyed it because, in addition to the affection bestowed upon his fine family, to whom he was devoted, he loved people and he loved work. That he was an indefatigable worker is proven by his whole career, which encompassed the threat of being a farmer but instead he chose to teach school and later took up the study of pharmacy and still later he studied medicine, being graduated by the College of Physicians and Surgeons in 1896. He was made a Demonstrator of Clinical Laboratory Diagnosis in 1898 and by 1916 was Professor of Clinical Medicine and remained in this position at the University of Maryland for 30 years, being made Professor Emeritus in 1946. During most of his career he was on the staffs of Mercy, Sinai, University, Church Home and Union Memorial Hospitals and, when the South Baltimore General Hospital was made a general hospital in 1918, he was named Chief of the Medical Staff and retained this position for many years, resigning because of pressure of other work.

The list of medical societies and other organizations, to which he belonged, covers two typewritten pages. I wish there were more time to detail his career. He was active in visiting clinics in this country and abroad, doing post graduate work in his early years in Vienna and Berlin and later visiting various hospitals in England, France and other countries.

We are in a room dedicated to a famous physician, who said, "the master word is work" and certainly Dr. Beck agreed with this philosophy. He soon established a large practice which increased as the years went on, eventuating in his private clinic, which was the only one of its kind in these parts. His being dedicated so wholeheartedly to his work did not preclude avocations such as becoming an enthusiastic and expert photographer and upon occasion lapsing into poetry. His medical writings were started early. The first record we have being of one published in 1899. Articles then appeared in journals at rather frequent intervals and in the meantime Dr. Julius Friedenwald, Dr. Beck and Dr. Hubert C. Knapp published a book in 1904 on "Clinical Laboratory Diagnosis."

The early papers had largely to do with laboratory techniques but as early as his twelfth paper published in 1909, he showed interest in the pituitary gland and his interest in endocrinology remained with him all his life. He published numerous papers dealing with this subject. Perhaps his next greatest interest was in chronic carbon monoxide poisoning, his first publication on this subject being in 1924 to be followed by many others. His writings, mostly on scientific subjects, total 70 publications, the last one being published in 1950, this paper being in the nature of a reversion to his first interests and was on "Orthostatic Albuminuria."

Dr. Beck was a man of determination, ability, almost limitless energy, thoroughness, gentleness and great kindness. He was fond of this Faculty. It is nice to have his writings in one volume prefaced by a short biographical account of his life prepared by loving hands. It is a great privilege to present to the Faculty this volume of the seventy publications, which are an index to Dr. Beck's interests and are the proof of some of the characteristics I have mentioned. Others, such as his modesty and cheerful laugh, could be appreciated only by knowing him.

---

[1] Gift of Mrs. Harvey G. Beck.

[2] Presented on Tuesday Afternoon, April 28, 1953, Osler Hall, Baltimore, Maryland, Annual Meeting, Medical and Chirurgical Faculty. (Part of 1953 Transactions.)

[3] Past President and Past Secretary, Member of Council, Medical and Chirurgical Faculty.

[4] Mrs. Archie I. Mahan, daughter of Dr. Beck.

Scientific Sessions

INTERRELATIONS OF THYROID AND IODINE METABOLISM[1]

T. S. DANOWSKI, M.D.[2]

The need for precise indices in studies of thyroid physiology is emphasized by the known limitations of basal metabolic rate measurements, lipid analyses, magnesium determinations, radioactive iodine pickup, incorporation, or excretion studies and even responses to therapy in evaluating specific patient situations. Enough data have now been accumulated on the utility and limitation of protein-bound or serum precipitable iodine levels in establishing the status of thyroid function to permit certain deductions concerning the interrelations of this gland and various aspects of health and disease.

I. Serum Iodine Fractions in Healthy Adults

It is known of course that the thyroid gland possesses an unique, or at least a highly developed, capacity to remove inorganic iodine from the blood circulating through it. This halide is then coupled with the amino acid tyrosine; molecules of halogenated amino acids are united to form the thyroxin molecule. This substance, in an as yet unidentified linkage with protein, is either the hormone of the thyroid gland or, in view of the metabolic effects of triiodothyronine, a closely related precursor. Thyroxin enters the colloid for variable periods of storage prior to being released to the circulation, and to the tissues. In the plasma it is under ordinary circumstances present in the protein-bound or serum precipitable fraction of iodine. One must keep in mind however that the plasma may also contain other iodine moieties such as a non-thyroxin protein-bound iodide and others.

With an intake of inorganic iodide limited to that present in an ordinary diet the inorganic plasma or serum iodine fraction is about 1 gamma per cent. Under similar circumstances the protein-bound or serum precipitable iodine (PBI or SPI) in euthyroid healthy individuals makes up some 4 to 8 gamma per cent. It has been established that during intervals of at least one and one-half to two months the protein-bound iodine remains relatively constant in any one individual (1). In one of the subjects in that particular series for example the variation from week to week was one-tenth of a gamma per cent or less. It would also appear that in adult females a tendency toward slight fluctuations may be evident during the ovulatory-menstrual cycle. These alterations do not vitiate the relative constancy of the serum precipitable iodine concentration, since the change is only a fraction of a gamma per cent. The trend toward an intermenstrual rise or a menstrual fall does nonetheless suggest an interrelationship, though it need not be directly endocrine in character.

Much more profound changes in serum iodine fractions, on the other hand, may be encountered, during pregnancy. Heinemann and coworkers were the first to report that during gestation unequivocal rises in the protein-bound iodine to concentrations distinctly above the usual range in healthy non-pregnant adult females can and usually do occur (2). We have shown that the thyroxin is also elevated (3). It is clear, however, that values of, for example, 7 gamma per cent for protein-bound iodine during pregnancy could represent a distinct elevation above prepregnancy levels of 4 or 5 gamma per cent. The mechanisms or adjustments whereby these rises are produced remain essentially obscure. The theoretical considerations are of course clear. The possibility that these rises represent the results of hemoconcentration can be readily dismissed in view of the expanded blood volume characteristic of pregnancy. Hence, the increased circulating protein-bound iodine and thyroxin levels must represent either a) an increase in the rate of production and release of thyroid hormone, b) a rise in the organic iodine binding capacity of serum proteins, or c) a decrease in the rate of its peripheral utilization or disposal. The pregnant patient however disposes of exogenous thyroxin at rates undistinguishable from those found in non-pregnant young adults (4). This excludes the last of the three possibilities but does not define the role of the remaining two in producing the rise in PBI during pregnancy.

---

[1] Harvey Grant Beck Memorial Lecture Annual Meeting, Medical and Chirurgical Faculty of the State of Maryland, Tuesday Afternoon, April 28, 1953, Osler Hall, Baltimore, Maryland.

This paper is a part of the 1953 Transactions.

[2] From the Department of Research Medicine and the Children's Hospital of Pittsburgh, University of Pittsburgh School of Medicine. Supported by grants from United States Public Health Service.

Spontaneous abortion on the other hand is frequently characterized by an absence of such increases in protein-bound iodine and thyroxin (5). Suggestive evidence is available indicating that in some of these patients desiccated thyroid or parenteral thyroxin may forestall this event (6). These correlations provide support for the time-honored obstetrical custom of thyroid administration to patients with infertility or abortion. They cannot be used however to explain all instances of prematurely terminated pregnancies since abortions do occur despite the presence of a characteristic pregnancy rise in PBI and thyroxin.

The course of the PBI following delivery is worthy of some comment. In a series of 95 women the PBI had returned by the fifth to seventh week to values indistinguishable from those characteristic of non-pregnant females of the childbearing age (7). Far more interesting however is the finding that in a large number of such subjects at a later date abnormally low PBI levels were present during the first year following delivery. These cannot be attributed to depressed albumin or globulin concentrations and hence might well indicate decreased thyroid activity and explain at least some of the postpartum fatigability ordinarily attributed to increased household burdens. There is no evidence one way or another that breast feeding, amenorrhea, or other events etiologically or temporarily related cause or prevent this drop, though this may well be so. Further observations are necessary however to determine whether or not these changes may represent temporary depression of thyroid hormone production or release, or a continued high rate of PBI degradation or excretion, or both.

II. Observations during Infancy and Childhood

Random sampling of the newborn population of a large obstetrical hospital has indicated that at term or shortly thereafter the serum protein-bound iodine levels are as high or higher than those present at that time in the mothers, individually or collectively (8, 9). During the first week of life the infants as a group manifest a further rise which is statistically significant. This may be solely related however to the loss of body weight and decrease in fluids which characterize this period. Subsequently the protein-bound iodine drops to ranges which fall within the adult euthyroid values, but at a level which exceeds the mean characteristic of the latter group of subjects. It seems reasonable to suggest that growth and development in early infancy is either facilitated or mediated by increased levels of circulating protein-bound iodine and thyroxin.

In view of the above speculation the obvious possibility suggests itself that premature infants might benefit by thyroid administration. Though this has been tried in the past, only small doses of thyroid were given (10). We have recently completed a study based on the premise that the requirements of the newborn infant for thyroid on a per kilogram of body weight basis may be much greater than those of the adult (11). The data suggest that this is indeed a fact and that the premature infant can be given up to 3 grains of desiccated thyroid or 0.2 mgm of thyroxin per day before manifestations of thyrotoxicosis appear. There is no clinical evidence that thyroid supplements in this larger range of dosage benefit the premature infant. These studies do indicate that adequate replacement therapy in cretinism requires thyroid in dosages larger than a fraction of a grain.

In another series of studies in diabetic and nondiabetic children certain provocative correlations have been demonstrated. Amongst these is the finding that the lowest protein-bound iodines in boys were present in the 12.1–14.9 year age group whereas in girls this was encountered in those who were between the 11.0–12.1th years of life (12). This points to the possibility that adolescence is associated with lowered levels of circulating protein-bound iodine. Another finding in this same series worthy of mention is related to intelligence quotients. In a small series of children intelligence quotients below 90 were associated with a significantly lower protein-bound iodine than that present on the average in subjects with intelligence quotients above 110. Perhaps the most reasonable interpretation which can be advanced is that there may be a correlation between this fraction of iodine and a generally inferior protoplasm. There is no reason to consider seriously the possibility that thyroid therapy would favorably affect the intelligence quotients of these patients, though this is being tested.

III. Protein-Bound and Thyroxin Iodine in Disease States

A. In Hyper- and Hypo-Thyroidism

The most distinctive and, clinically, most useful correlations between protein-bound iodine and thyroid function are encountered in myxedema or hypothyroidism and in thyrotoxicosis (13, 14, 15). Assuming the absence of factors which will be identified later, a close correlation is present between the degree of thyroid function, the level of metabolic activity, and the concentration of circulating protein-bound or serum percipitable iodine. The euthyroid range of this serum fraction lies within 4 and about 7.5 or 8 gamma per cent. Values below this range usually indicate thyroid underfunction; those above, point to thyroid over-activity. It should be emphasized however that in evaluating any particular analytical result the error of the method must be kept in mind. Since this is about 0.3 gamma per cent, and at times probably greater, it is obvious that figures beyond the decimal point at the limits tentatively set for either end of the scale will at times be of questionable validity. However, if these equivocal situations are excluded, the protein-bound or serum precipitable iodine is usually a highly reliable index of thyroid activity. This has been established by extensive and well-documented series of clinical situations in which the symptoms, physical findings, and laboratory analyses have been correlated with changes following upon the use of iodine solutions, goitrogens, or radioactive iodine with or without surgical therapy (13, 14, 15). It should be pointed out however that the circulating protein-bound iodine would not rise if the peripheral utilization increases at the same rate. Fortunately, from the view of the clinical problems encountered, a lag appears to be present. Hence in most instances the protein-bound iodine remains elevated above euthyroid limits despite the increased peripheral disappearance of the hormone. With diminution or cessation of hormone production on the other hand the circulating levels invariably decline and even reach zero. However, in evaluating any particular serum precipitable iodine concentration it should be remembered that a delay may well be present in the appearance of changes in the serum. This is certainly true in the case of complete thyroidectomy or in the withdrawal of exogenous thyroid from subjects with total myxedema. It may take as long as six weeks before the last detectable vestige of the serum protein-bound iodine disappears.

B. In Thyroiditis

Only a limited number of observations have been made of the protein-bound iodine levels in patients with acute thyroiditis. In two out of three such individuals observed in this laboratory elevations into the so-called hyperthyroid range have been encountered (16). In one instance a value of 12.3 gamma per cent was found. Similar changes have been recorded by others (17). In none of these was there any clinical evidence of hypermetabolism. It seems probable that during the inflammatory process thyroxin and organic iodine compounds other than thyroxin are released into the circulation and augment the protein-bound iodine. It is not known what proportion of the rise is to be attributed to thyroxin and what to non-thyroxin compounds. The ultimate risk in these subjects is hypothyroidism or myxedema, as a consequence of the scarring and fibrosis which occur, with the serum protein-bound iodine low or absent.

C. In Hypoproteinemia

Since the circulating organic iodine fractions consist of combinations of iodine compounds with serum proteins, it is not unexpected that changes in the latter may influence the concentrations of protein-bound iodine. Peters and Mann have demonstrated that this is indeed the case in some but not all instances of hypoalbuminemia (18). Certain patients with nephrosis, liver disease, and other disorders with associated changes in the serum proteins have been found to have abnormally low levels. This does not appear to be, however, a sign of hypothyroidism, but rather a reflection of changes in the plasma transport system upon which the level of the iodine fractions depends.

D. In Miscellaneous Clinical States

It has been previously reported that in leukemia the protein-bound iodine is normal or elevated (19). We have found that the PBI and thyroxin level is within the euthyroid range (20).

In a series of 50 cardiac patients in congestive failure we have encountered an unexpectedly high incidence of abnormally high or low protein-bound iodine values (21). On clinical grounds none of these patients was suspected to have thyroid dysfunction. It is obvious that the existence of either thyroid hypo- or hyper-activity might well play an important if not a decisive role in the appearance of congestive symptoms and signs. This observation adds assurance to the clinical practice of treating cardiac patients, for a while at least, as if an element of thyrotoxicosis were present. The disadvantages or dangers of marked hypothyroidism must of course also be kept in mind.

Some comment is in order concerning the role of the central nervous system and the hypothalamus on thyroid activity. It is known that patients with organic lesions at the base of the brain tend to run low protein-bound iodine values (22). Whether or not these represent changes of the type seen in pituitary myxedema is not clear. Neither do we know anything about the TSH secretion in such subjects. In an attempt to answer some of the obvious questions we have been testing parahydroxypropiophenone (23). This compound has been reported to suppress thyroid-stimulating hormone secretion; to date studies in this country have failed to confirm this finding (23, 24).

Finally, the advent of 11-oxygenated steroids and of ACTH has led to the observation that these substances also suppress circulating PBI and thyroxin (25, 26). This appears to be related to decreased production of thyroid hormone. Its importance during treatment with these agents has already been voiced by others (27), who have pointed out that the therapeutic efficiency of these agents may be adversely affected.

IV. IODINE FRACTIONS DURING THE INGESTION OF INORGANIC IODIDES

The intake of as little as 0.2 to 0.4 grams of potassium iodide daily is associated with a slight but unequivocal increase in the serum precipitable iodine by the end of four weeks or earlier. At that time the upper limit of normal is usually reached or even exceeded (28). In such subjects the inorganic iodide level is considerably elevated, ranging between 100 to 300 gamma per cent. The use of an inorganic iodide in somewhat greater dosage, 0.6 grams daily, is associated with higher inorganic iodide values and an indisputable rise in the protein-bound iodine. Finally dramatic rises in the inorganic iodide up to as high as 22,000 gamma per cent, and in the protein-bound fraction up to 33 gamma per cent have been recorded in patients receiving massive daily doses of potassium iodide during sufficiently prolonged intervals (29).

Certain possibilities should be considered in discussing the mechanisms whereby these rises are induced. First the question as to the reality of the increase in protein-bound iodine can be promptly dismissed. These observations are not artefacts resulting from incomplete removal of inorganic iodide. Control studies have convincingly demonstrated that 14 washings of the precipitated serum with suitable portions of iodine-free water completely remove all inorganic iodide not bound to protein. This finding is confirmed by the excellent agreement in the analyses of samples washed both 14 and 18 times, indicating that all free inorganic iodide has been eluted. The persistence of high protein-bound iodine values following the cessation of iodide therapy and the return of the serum inorganic fraction of this halide to ordinary levels again supports the interpretation that the organic iodine fraction has indeed risen. It is conceivable that the observed increases in protein-bound iodine were mediated through the thyroid gland. The work of Taurog and Chaikoff in which the thyroxin content of rat glands rose ten-fold during iodide therapy makes such a mechanism plausible (30). Unfortunately analyses of human thyroids during or after such treatment are not available. Serum thyroxin studies in the studies cited above (29) based on the relative solubilities of serum iodine fractions in butanol and a mixture of NaOH and Na_2CO_3 provide a partial answer to this question. It is clearly evident from the studies cited that in no instance was the rise in protein-bound iodine accompanied by an increased thyroxin concentration. This certainly indicates that the non-thyroxin moiety of the protein-bound iodine has risen during iodide administration. Though it is conceivable that this rise was mediated through the thyroid gland, the alternative possibility however of an *in vivo* iodination of serum proteins must be kept in mind. Up to this time it has not been possible to reproduce these results *in vitro* by the incubation of serum or blood for relatively short intervals up to five days in length (31). These results pointing to a rise in the non-thyroxin protein-bound iodine while iodide is administered are in keeping with the clinical findings in such subjects. Hypermetabolic effects were conspicuous by their absence, and furthermore, such rises failed to correct the hypometabolism of myxedematous individuals.

These effects in humans have been reproduced in rats irrespective of the route of inorganic iodide therapy, i.e., either oral or parenteral iodide administration raised the non-thyroxin portion of the protein-bound iodine. On the other hand the subcutaneous injection of elemental iodine in propylene glycol increases to a modest degree the circulating thyroxin while inducing marked increments in the circulating protein-bound iodine (32, 33). These observations fit in very well with the convincing morphological and histological studies of Dvoskin which indicated without cavil that injected elemental iodine effectively replaced the secretion of the thyroid gland in influencing body growth, adrenal weight, and thyroid histology (34). Our own contribution to the problem unfortunately both answers and raises questions (33). Though goitrogens do influence the magnitude of the protein-bound and thyroxin iodine change, we cannot at this point state the degree to which, if any, this represents influence over the extrathyroidal formation of thyroxin. More precise answers should become available in studying animals which are truly athyroidal established as such either by thyroidectomy or by serial and detailed histological examination, or by I^{131} and circulating PBI studies. Finally, it should be pointed out that if such extrathyroidal syntheses of materials mimicking thyroid hormone are occurring, and the bulk of evidence indicates this is indeed so, the question immediately arises as to whether or not this is mediated through enzyme systems related to those functional in the thyroid itself. A partial answer is available from our rat studies in which rises of protein-bound iodine were influenced in part by propylthiouracil (33).

V. Studies of Protein-Bound Iodine during and following Ingestion of Desiccated Thyroid

Certain thyroid feeding experiments have further defined the response of endogenous thyroid hormone production during supplemental or replacement therapy. Tracer I^{131} studies have indicated that ingestion of desiccated thyroid depresses the trapping of iodide by the thyroid gland (35). Experiments in this laboratory indicate that usually more than 3 grains of thyroid have to be given each day to healthy young adults before the circulating protein-bound iodine rises above pre-treatment levels (36). Upon withdrawal of the medication, and irrespective of whether or not a change did occur during therapy, the protein-bound iodine dropped abruptly below values characteristic of the individual under study. This again points to suppression of the endogenous production of thyroid hormone, and is in keeping with similar observations made in patients receiving up to 25 grains of desiccated thyroid daily (37). These findings have a therapeutic implication since they suggest that thyroid administration to euthyroid subjects in amounts such as 1 or 2 grains merely replaces an equivalent endogenous production of hormone. The net effect is a zero change. This would of course not hold in hypothyroid individuals nor would it apply to dosages in excess of the daily output by the gland.

Summary and Conclusions

In recapitulating the known facts about the serum iodine fractions in healthy adults it can be stated with fair assurance that the protein-bound and thyroxin moieties remain relatively constant during intervals up to at least several months in length. Menstruation or ovulation, or both, appear to be associated with minor fluctuations. Uncomplicated pregnancy is characterized by early rises in protein-bound iodine and thyroxin; in many patients who abort spontaneously such rises have failed to occur. Abnormally low protein-bound iodine values are frequently present during the first year postpartum, suggesting that pregnancy may be followed by a period of hypothyroidism.

Studies in children indicate that at birth protein-bound iodine levels are high, reflecting in part the elevation present in the mother and in part the great need for thyroid hormone during this very active phase of growth and development. The administration of thyroid to premature infants does not accelerate their maturation but does show that compared to adults, on a per kilogram of body weight basis, larger amounts of desiccated thyroid must be given before symptoms of thyrotoxicosis are elicited. In older children comparable levels of protein-bound iodine have been found in diabetic and in non-diabetic children. At the approximate time of pubescence the iodine value drops in both groups.

In addition to its usefulness in setting up correlations of the type cited above the protein-bound iodine levels offer a precise way of identifying hyper- and hypo-thyroidism. The feeding of inorganic iodine in large doses or for prolonged periods of time, the ingestion of desiccated thyroid, and the administration of organic substances such as lipiodol, produce elevations in protein-bound iodine not attributable to hyperthyroidism. A combination of analytic and clinical techniques will usually serve to identify such high values. On the other hand alterations in serum proteins or withdrawal of desiccated thyroid medication may be accompanied by low protein-bound iodine values in the absence of hypothyroidism.

REFERENCES

1. Danowski, T. S., Hedenburg, S., and Greenman, J. H.: The constancy of the serum precipitable or protein-bound iodine in healthy adults. J. Clin. Endocrinol. **9:** 768, 1949.
2. Heinemann, M., Johnson, C. E., and Man, E. B.: Serum precipitable iodine concentrations during pregnancy. J. Clin. Invest. **27:** 91, 1948.
3. Danowski, T. S., Gow, R. C., Mateer, F. M., Everhart, W. C., Johnston, S. Y., and Greenman, J. H.: Increases in serum thyroxin during uncomplicated pregnancy. Proc. Soc. Exper. Biol. Med. **74:** 323, 1950.
4. Danowski, T. S., Mateer, F. M., and Wirth, P.: Unpublished data on thyroxin tolerances.
5. Man, E. B., Heinemann, M., Johnson, C. E., Leary, D. C., and Peters, J. P.: The precipitable iodine of serum in normal pregnancy and its relation to abortions. J. Clin. Invest. **30:** 137, 1951.
6. Peters, J. P., Man, E. B., and Heinemann, M.: Pregnancy and thyroid gland. Yale J. Biol. and Med. **20:** 449, 1948.
7. Danowski, T. S., Huff, S. J., Mrvos, D., Wirth, P., George, R. S., and Mateer, F. M.: Is pregnancy followed by relative hypothyroidism? Am. J. Ob. and Gyn. **65:** 77, 1953.
8. Danowski, T. S., Johnston, S. Y., Price, W. C., McKelvy, M., Stevenson, S. S., and McCluskey, E. R.: Protein-bound iodine in infants from birth to one year of age. Pediatrics **7:** 240, 1951.
9. Man, E. B., Culotta, C. S., Siegfried, D. A., and Stilson, C.: Serum precipitable iodines in recognition of cretinism and in control of thyroid medication. J. Pediat. **31:** 154, 1947.
10. Moncrieff, A.: The administration of thyroid gland to premature babies. Arch. of Dis. in Child. **13:** 57, 1938.
11. Stevenson, S. S., Wirth, P., Bastiani, R., and Danowski, T. S.: Some effects of exogenous thyroid or thyroxin upon premature infants. Pediatrics. In press.
12. Danowski, T. S., Huff, S. J., Erhard, L. H., Price, M., Brown, M., Wirth, P., and Stevenson, S. S.: Protein-bound iodine levels in normal and in diabetic children. A.M.A. Am. J. Dis. Child. **84:** 5, 1952.
13. Man, E. B., Smirnow, A. E., Gildea, E. R., and Peters, J. P.: Serum iodine fractions in hyperthyroidism. J. Clin. Invest. **21:** 773. 1942.
14. Winkler, A. W., Riggs, D. S., Thompson, K. W., and Man, E. B.: Serum iodine in hyperthyroidism, with particular reference to the effects of subtotal thyroidectomy. J. Clin. Invest. **25:** 404, 1946.
15. Winkler, A. W., Man, E. B., and Danowski, T. S.: Minimum dosage of thiourea, given together with iodine medication, necessary for the production and maintenance of a remission in hyperthyroidism. J. Clin. Invest. **26:** 446, 1947.
16. Danowski, T. S.: Unpublished data.
17. Robbins, J., Rall, J. E., Trunnell, J. B., and Rawson, R. W.: The effect of thyroid-stimulating hormone in acute thyroiditis. J. Clin. Endocrinol. **11:** 1106, 1951.
18. Peters, J. P., and Man, E. B.: The relation of albumin to precipitable iodine of serum. J. Clin. Invest. **27:** 397, 1948.
19. Curtis, G. M., and Fertman, M. B.: Blood iodine studies. Arch. Surg. **54:** 541, 1947.
20. Peters, J. H., and Danowski, T. S.: Unpublished data.
21. Shaler, J., Greenman, L., and Danowski, T. S.: Unpublished data.
22. Peters, J. P., German, W. J., and Man, E. B.: Serum precipitable iodine in patients with tumors of or near the pituitary. J. Clin. Endocrinol. **9:** 1292, 1949.
23. Danowski, T. S., Wirth, P., Brown, M., Hill, G. C., and Fetterman, G. H.: Parahydroxypropiophenone effects on rat thyroid, adrenal, and pituitary. J. Clin. Endocrinol. and Metab. **12:** 1454, 1952.
24. Money, W. L., Lucas, V., Fager, J., and Rawson, R. W.: The effects of p-hydroxypropiophenone on the thyroid gland of experimental animals. J. Clin. Endocrinol. **11:** 973, 1951.
25. Hardy, J. D., Riegel, C., and Erisman, E. P.: Experience with protein-bound iodine (PBI); the effect of ACTH and cortisone on thyroid function. Am. J. Med. Sci. **220:** 290, 1950.
26. Towery, B. T.: Changes in the protein-bound iodine and the clinical course of thyrotoxic crisis treated with ACTH. J. Clin. Invest. **31:** 667, 1952.
27. Thorn, G. W., Forsham, P. H., Frawley, T. F., Hill, S. R., Jr., Roche, M., Staehelin, D., and Wilson, D. L.: The clinical usefulness of ACTH and cortisone. New Eng. J. Med. **242:** 783, 824, 865, 1950.
28. Danowski, T. S., Mateer, F. M., Weigand, F. A., Peters, J. H., and Greenman, J. H.: Serum iodine fractions in subjects receiving potassium iodide in small dosage. J. Clin. Endocrinol. **10:** 532, 1950.
29. Danowski, T. S., Johnston, S. Y., and Greenman, J. H.: Alterations in serum iodine fractions induced by the administration of inorganic iodide in massive dosage. J. Clin. Endocrinol. **10:** 519, 1950.
30. Taurog, A., and Chaikoff, I. L.: The relation of the thyroxine content of the thyroid gland and of the level of protein-bound iodine of plasma to iodine intake. J. Biol. Chem. **165:** 217, 1946.
31. Greenman, J. H., Huff, S. J., and Danowski, T. S.: Unpublished data.

32. Barker, S. B., and Lipner, H. J.: *In vivo* iodination of tissue protein following injection of elemental iodine. Science **108:** 539, 1948.
33. Danowski, T. S., Huff, S. J., Wirth, P. M., Hill, G. C., Green, M. H., and Fetterman, G. H.: Protein-bound iodine of rats receiving iodide or iodine with or without goitrogen. J. Clin. Endocrinol. **11:** 1254, 1951.
34. Dvoskin, S.: The thyroxine-like action of elemental iodine in the rat and chick. Endocrinol. **40:** 334, 1947.
35. Greer, M. A.: The effect on endogenous thyroid activity of feeding desiccated thyroid to normal human subjects. New Eng. J. Med. **244:** 385, 1951.
36. Danowski, T. S., Huff, S. J., Tarail, R., Wirth, P., Peters, J. H., Mateer, F. M., and Garver, K.: Serum protein-bound iodine during ingestion of desiccated thyroid. J. Clin. Endocrinol. and Metab. **12:** 1572, 1952.
37. Riggs, D. S., Man, E. B., and Winkler, A. W.: Serum iodine of euthyroid subjects treated with desiccated thyroid. J. Clin. Invest. **24:** 722, 1945.

EXCISION OF AORTIC ANEURYSMS*

HENRY T. BAHNSON, M.D.†

Many forms of surgical treatment have been applied to aneurysm of the aorta, but those which have been of more than passing interest may be grouped under the following headings. *Ligation* is applicable only to aneurysms in the distal aorta and there is considerable risk to both patient and his extremities. *Wiring*, particularly with Dr. Blakemore's method of electrothermic coagulation, has given good results, but in our hands a number of aneurysms so treated have subsequently progressed in size. So called "*cellophane wrapping*" has been widely used, but even when the material is coated with dicetyl phosphate the results are inconstant. *Endoaneurysmorraphy* is an established method on peripheral arteries but has been rarely used on the aorta. There are a few scattered reports of *excision* of aortic aneurysms, but except for Tuffier in the early 1900's and recently Cooley and De Bakey most of these authors have not advocated excision. I shall attempt to show that excision is feasible in all regions of the aorta and that in many instances it is the treatment of choice.

The principle causes of aortic aneurysms are two, namely arteriosclerosis and syphilis (Fig. 1). There are occasional aneurysms caused by trauma or bacterial infection but in general these resemble aneurysms due to syphilis. Syphilitic aneurysms usually occur in the thorax and almost always above the renal arteries. They are saccular, tend to occur in younger individuals and are often associated with pain or erosion of bone. The prognosis for such patients is quite poor, as only 18 of 633 patients reported by Kampmeier lived for more than two years. Most patients with aneurysms due to syphilis will die within six to nine months from the onset of symptoms. Arteriosclerotic aneurysms are usually fusiform, occur in older patients, below the renal arteries, and are usually not associated with significant pain or erosion of bone. About one out of five patients seen with arteriosclerotic aneurysms will die within a year of rupture of the aneurysm and over half of them will die within eight years.

Both types of aneurysms are amenable to excision. Aneurysms due to syphilis are usually localized ruptures with a narrow mouth. If this point of maximum weakness can be removed, the remaining aorta may be functionally adequate. On the other hand the position of arteriosclerotic aneurysms in the terminal aorta allows occlusion of the aorta for excision and aneurysmorraphy or substitution by a homograft.

---

* Presented at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, Tuesday Morning, April 28, 1953, Osler Hall, Baltimore, Maryland, under the title, "Surgical Treatment of Aortic Aneurysms."

† From the Department of Surgery, The Johns Hopkins University School of Medicine and The Johns Hopkins Hospital. Aided by a grant from U. S. Public Health Service, National Institutes of Health, Bethesda, Maryland.

The following cases illustrate our method of handling aneurysms in various regions of the aorta.

Aneurysms on the convexity of the ascending aorta are particularly accessible to surgical attack. However, the mouth of the aneurysm must be isolated and occluded since the aorta in this region cannot be obstructed for more than a very short period.

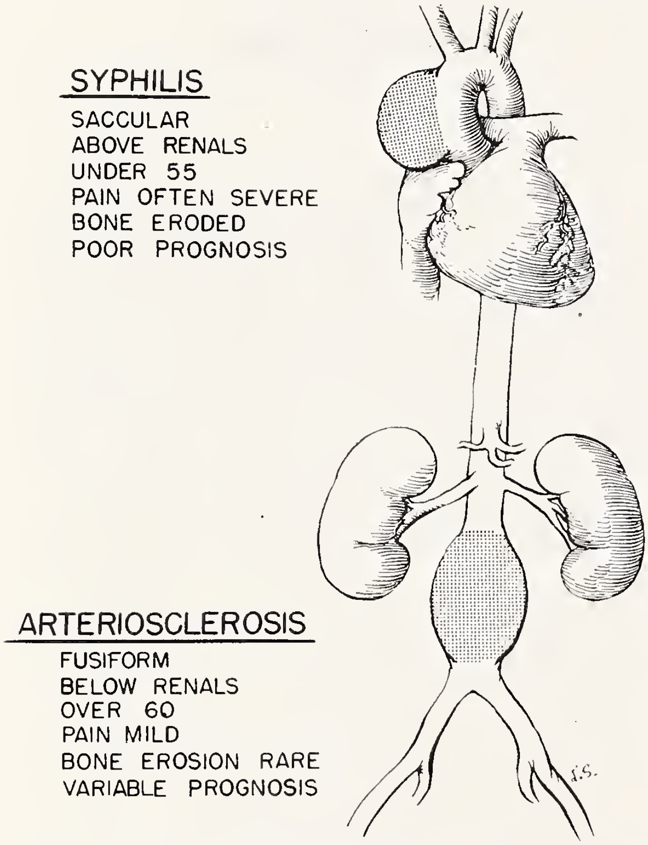


FIG. 1. Diagram illustrating two principal types of aortic aneurysms with their clinical characteristics.

Such a case is illustrated by a 51 year old colored male in whom the diagnosis of syphilitic aneurysm was made in 1951. At that time he had dyspnea paroxsymally at night, dyspnea on exertion and substernal pain which was worse after eating and often kept him awake at night. These symptoms became more pronounced, and he lost 21 pounds in the year preceding admission.

On examination there was venous distention in his arms and neck but not in the lower extremities. Dullness and a definite pulsation were present in the first two intercostal spaces to the right of the sternum. There was no evidence of aortic insufficiency or cardiac failure.

On roentgenography a mass in the right mediastinum was noted which pulsated and pushed the lower trachea and right main bronchus posteriorly. The esophagus was deviated to the left at this level. Angiocardiography showed marked compression and partial obstruction of the superior vena cava which limited opacification of the aorta. A small polyethylene catheter was inserted percutaneously into a femoral artery and advanced to the ascending aorta. Injected contrast medium showed a saccular aneurysm on the right lateral wall of the mid-portion of the ascending aorta. There was no evidence of clot.

The right thoracic cavity was entered through the fourth intercostal space and the sternum was split upwards in the midline. The aneurysm was inside the pericardium. The mouth of the aneurysm was dissected free without disturbing intimate attachments to the right pulmonary artery and superior vena cava. The mouth was occluded with a straight intestinal clamp, the ends of which were compressed manually as the aneurysm was opened and three curved Potts coarctation clamps were applied to the cut edges. The opening was closed with two rows of interrupted fine silk sutures. The patient made an uneventful recovery.

The first patient we treated by excision was a 56 year old man referred to Johns Hopkins because of shortness of breath of four months duration. He was unable to work and was dyspneic at rest. There was evidence of syphilis. On tracheoscopy an extrinsic mass almost occluded the trachea by pressure from the left in the region of the aorta. Laminography demonstrated this striking compression. Angiocardiography showed a small but strategically located aneurysm on the dome of the aortic arch. We opened the chest widely, splitting the second left interspace and the sternum (Fig. 2, a). The aneurysm arose from the medial portion of the aortic arch behind the left common carotid artery just proximal to the origin of the left subclavian. The left subclavian artery was ligated and a clamp placed across the base of the aneurysm and the aortic arch (Fig. 2, b). The aneurysm was excised and the base of it closed without difficulty by numerous fine sutures. In removing the sac, which incidentally is a must to prevent subsequent infection and rupture, the wall of the sac was fused to the trachea. Flattened cartilages were in direct contact with blood and clot. Apparently rupture had been imminent. Tracheotomy was necessary after operation to aspirate the profuse bronchial secretions. A bronchogram and esophogram taken two weeks after operation just prior to removal of the tracheotomy tube showed normal position of both structures (Fig. 3, c). He was ready to return to work two months later, and at last report, six months after operation, he was well, although in the Maryland House of Correction.

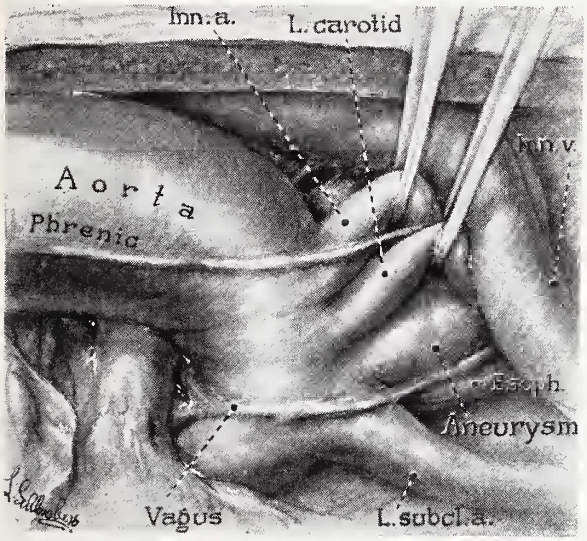


Fig. 2a

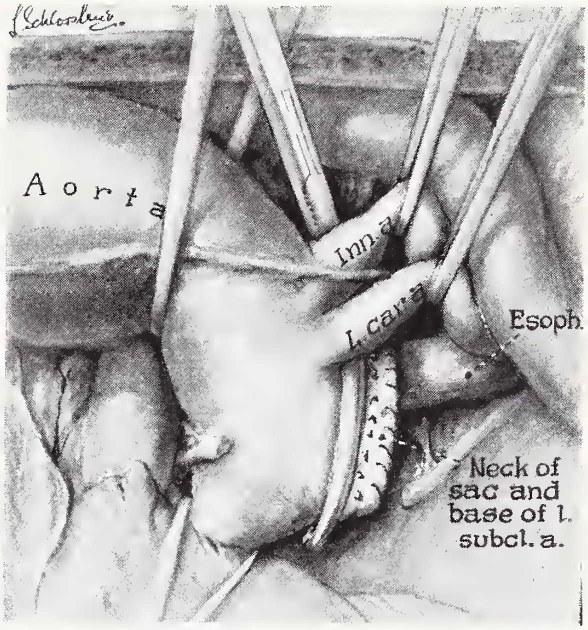


Fig. 2b

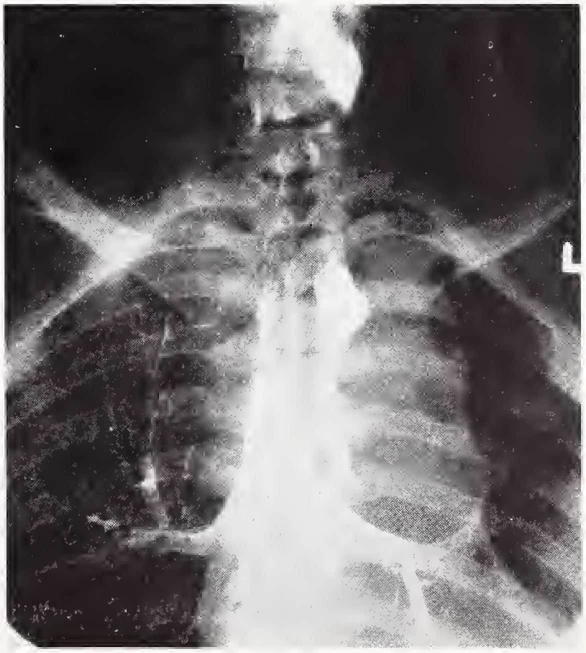


Fig. 2c

Fig. 2. A 56 year old man was seen because of progressive dyspnea. Marked compression of the trachea was demonstrated in the region of the aorta. The aneurysm was excised from the aortic arch, and the patient is well.

a. Exposure was through the second left interspace and split sternum. The aneurysm arose from the medial side of the aortic arch behind the left common carotid and subclavian arteries.

b. The left subclavian was ligated, a clamp placed across the base of the aneurysm and the aortic arch, and the aneurysm was excised. Closure was with numerous fine silk sutures.

c. Visualization of the trachea and esophagus 2 weeks after operation shows normal position and lumen of both.

One of our patients was a 49 year old registered nurse who sustained an injury to her chest in an automobile accident in October 1950. After regaining consciousness she was dyspneic and had a sense of painful compression in the midsternal region. Hoarseness was soon noted. At no time could a blood pressure measurement be obtained in her left arm. Roentgenograms at that time showed no intrathoracic abnormality, but a month later a pulsating mass was discovered in the left upper mediastinum. She was referred to Dr. H. William Scott at Johns Hopkins in June 1951. There was a significantly lower blood pressure in the left arm than the right. There was no evidence of syphilis. Angiocardiography showed a saccular aneurysm at the terminal portion of the aortic arch with considerable clot in the wall (Fig. 3, a). Dr. Scott wrapped the lateral surface of the aneurysm with reactive polythene film. Convalescence was uneventful and she became asymptomatic. Her voice returned to normal but four months later hoarseness reappeared. Later pain reappeared in the upper chest. She returned to the hospital in September, 1952, for reevaluation. Repeat angiocardiography and chest film showed little if any change in the configuration of the aneurysm, and operation was thought advisable. At operation the aorta and vessels arising from the arch were isolated (Fig. 3, b). The aneurysm arose from the terminal portion of the aortic arch. The left subclavian arose from the aneurysm itself. The aortic arch just proximal to the left common carotid artery and the upper thoracic aorta were cross-clamped for seven minutes during which time the aneurysm was opened. A discrete circumferential tear was seen in the aorta at the site of origin of the left subclavian artery. The anterior portion of the opening was easily sutured

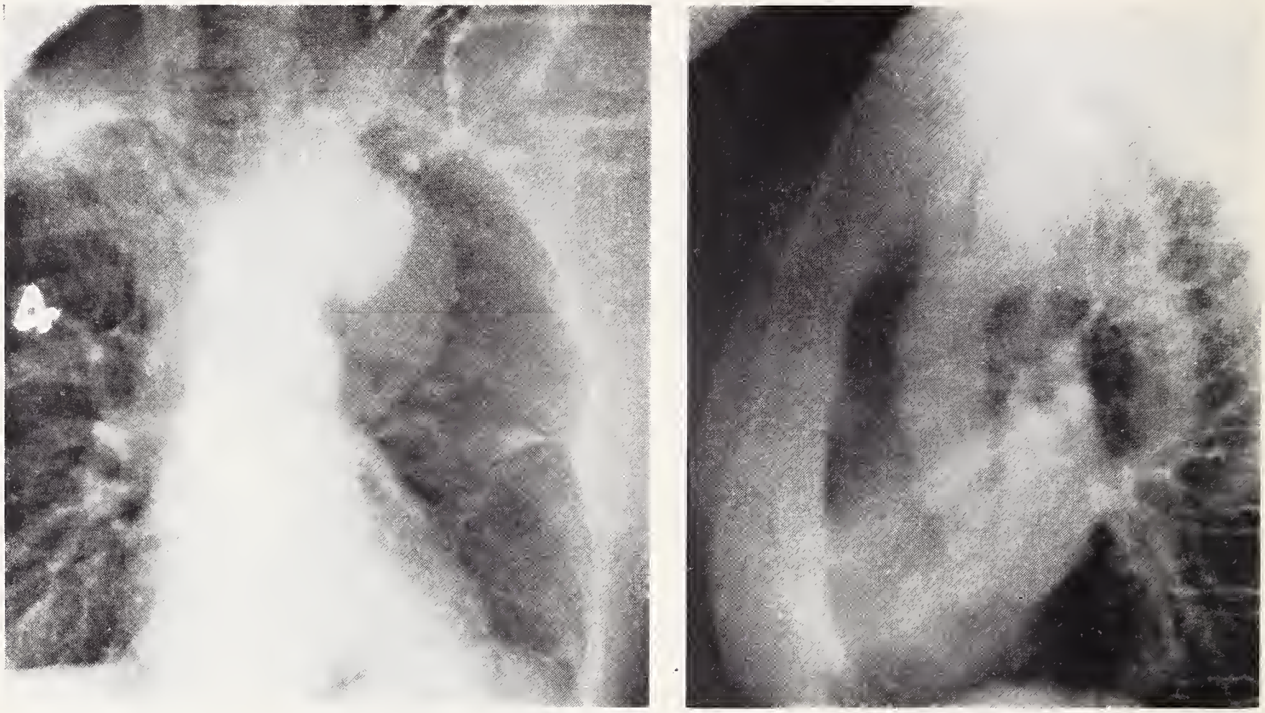


FIG. 3a

FIG. 3. A 49 year old nurse sustained an injury to her chest which resulted in an aneurysm in the terminal portion of the aortic arch. There was temporary improvement following "cellophane wrapping," but later reactivation occurred and excision was carried out successfully.

a. Antero-posterior and lateral angiocardiograms showing the saccular aneurysm of the terminal portion of the aortic arch.

b. Operative exposure shows the aneurysm of the distal aortic arch with the left subclavian artery arising from the aneurysm itself (upper drawing). The lower drawing shows the aneurysm opened and closure of the narrow mouth begun. The aorta was occluded proximal to the left common carotid artery and distal to the aneurysm for 7 minutes.

from inside the aneurysm. Because of beginning hypotension and cardiac irregularity cross clamping of the aorta was discontinued before the entire opening could be sutured. The hole in the aorta was controlled by manual compression against the spine and aorta while the aneurysm was completely mobilized and the opening closed. She has done well since operation.

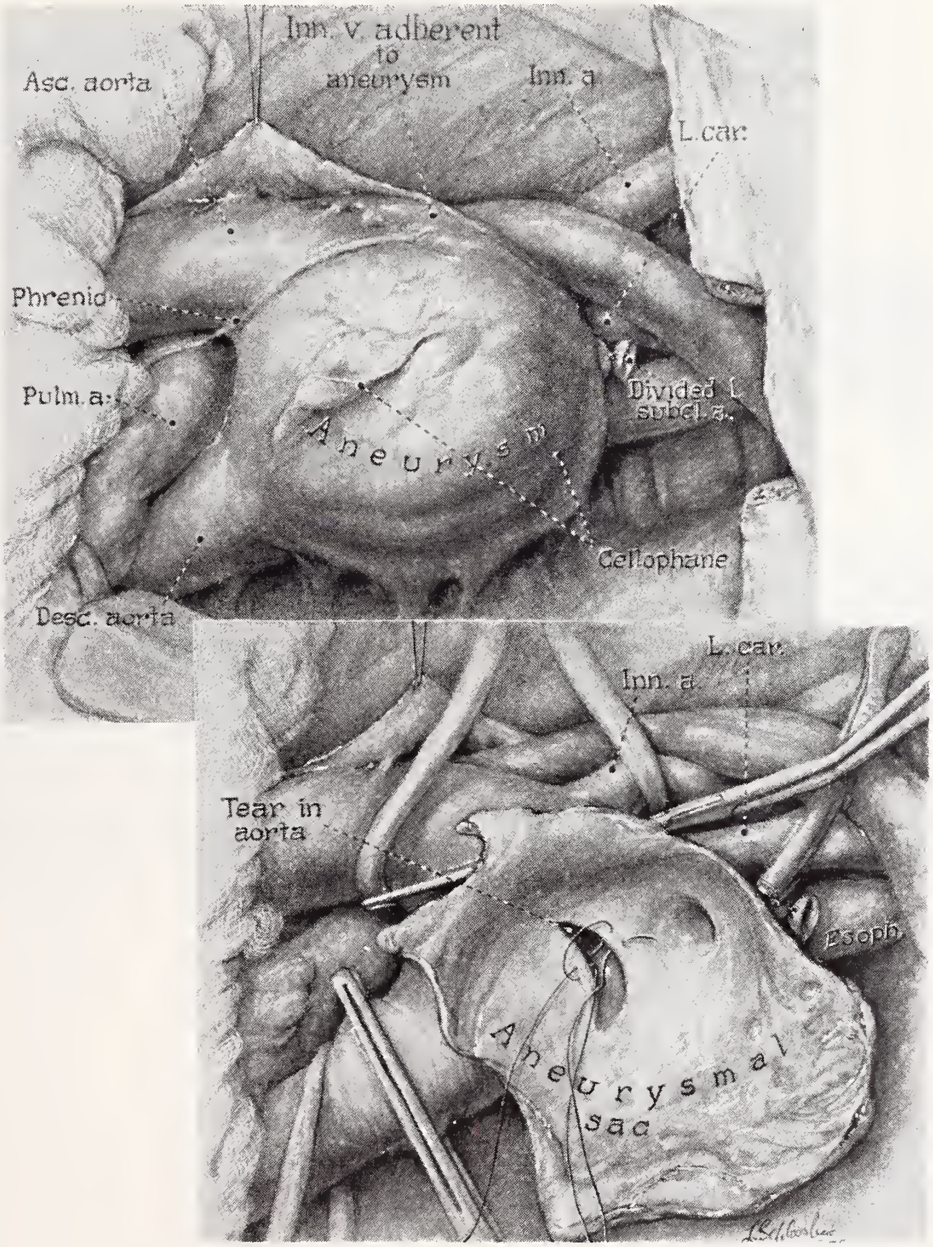

Inn. v. adherent to aneurysm
Asc. aorta
Inn. a.
L. car.
Phrenic
Pulm. a.
Aneurysm
Divided L subcl. a.
Cellophane
Desc. aorta
L. car.
Inn. a.
Tear in aorta
Esoph.
Aneurysmal sac

Fig. 3b

A 45 year old colored male who had pain in his back following an automobile accident was seen a year after the injury when a pulsating mass appeared in the left costo-vertebral angle. Aortography by Dr. Willard Goodwin showed a bilobate upper abdominal aneurysm (Fig. 4, a). Wiring and electrothermic coagulation were performed with what we thought was a satisfactory result. After a brief remission the mass enlarged and when readmitted about a year ago there was a large mass in the left flank which encroached on the costal margin above and the iliac crest below (Fig. 4, b). Aortography showed considerable enlargement of the lumen of the aneurysm and an additional 300 feet of stainless steel wire was inserted. There was considerable relief of pain but the mass seemed to enlarge. Excision was thought indicated. Wide exposure was obtained through the bed of the tenth rib and a thoraco-abdominal incision. The abdominal viscera were displaced forward and to the right (Fig. 4, c). The mouth of the aneurysm extended from just posterior to the origin of the celiac axis down to the level of the renal arteries, a distance of 12 to 15 centimeters. The vessels and aorta proximally and distally were isolated and occluded for 37 minutes while the aneurysm was excised and the aorta reconstructed from aneurysmal wall. Vertebral bodies, spinal nerves and in one area dura were exposed to blood in the aneurysmal lumen. Just prior to discharge an aortogram showed a tortuous aorta but a relatively normal lumen (Fig. 4, d). He had a long convalescence but when recently seen, over a year after operation, he was well.

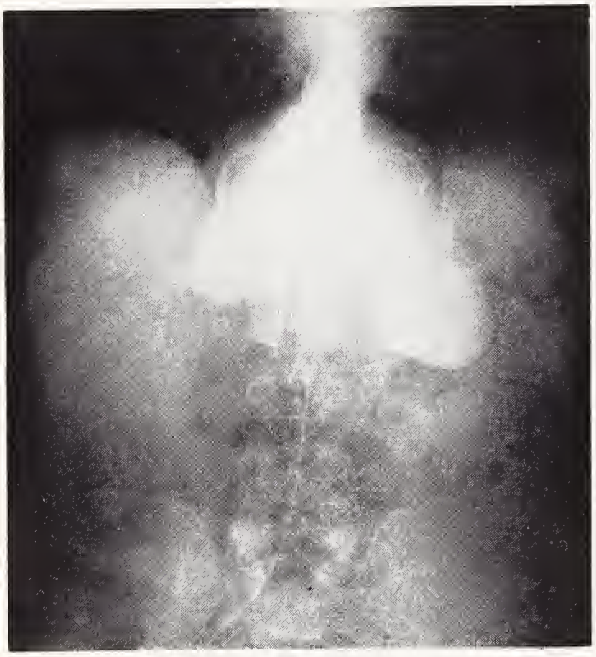


FIG. 4a

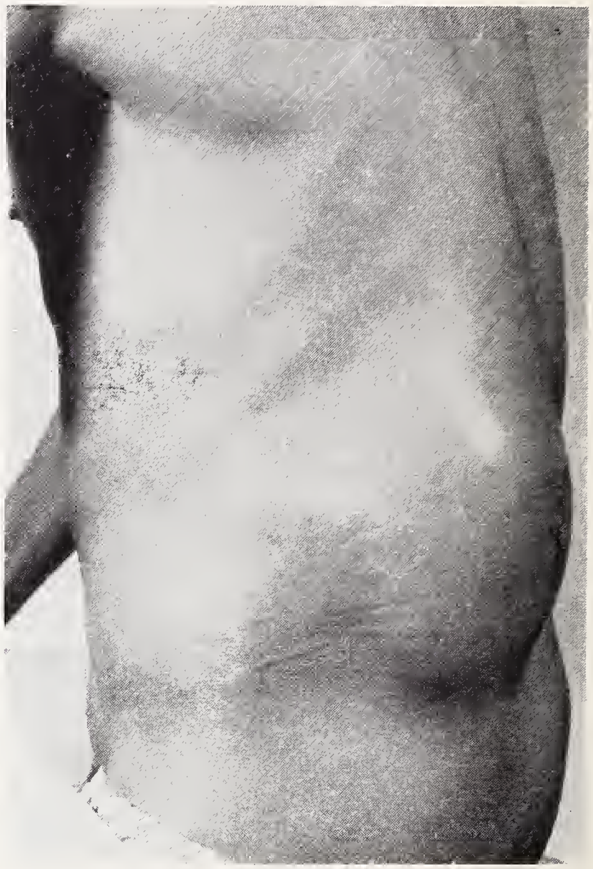


FIG. 4b

FIG. 4. A 45 year old man was seen with a painful upper abdominal aneurysm. Wiring and electrothermic coagulation relieved the pain and pulsation ceased. The mass later enlarged and symptoms recurred. The aneurysm was excised and aorta reconstructed from wall adjacent to the mouth. The patient is now well after a long convalescence.

a. Initial aortogram shows a bilobate upper abdominal aortic aneurysm. This was inactivated by wiring and electrothermic coagulation, but the aneurysm subsequently enlarged and extended into the pelvis.

b. At the time of second hospital admission the mass encroached on costal margin above and iliac crest below.

c. Thoraco-abdominal exposure through the bed of the tenth rib. Abdominal aorta and viscera were displaced forward by the large aneurysm. Visceral branches and the aorta proximal and distal to the aneurysm were occluded for 37 minutes while the aneurysm was excised and the aorta reconstructed. Vertebral bodies, spinal nerves and dura were exposed to blood in the aneurysmal lumen.

d. Aortogram 1 month after excision shows a tortuous aorta with a relatively normal lumen.

As an example of an arteriosclerotic aneurysm a 67 year old man noted a pulsating abdominal mass over a year before admission when he was

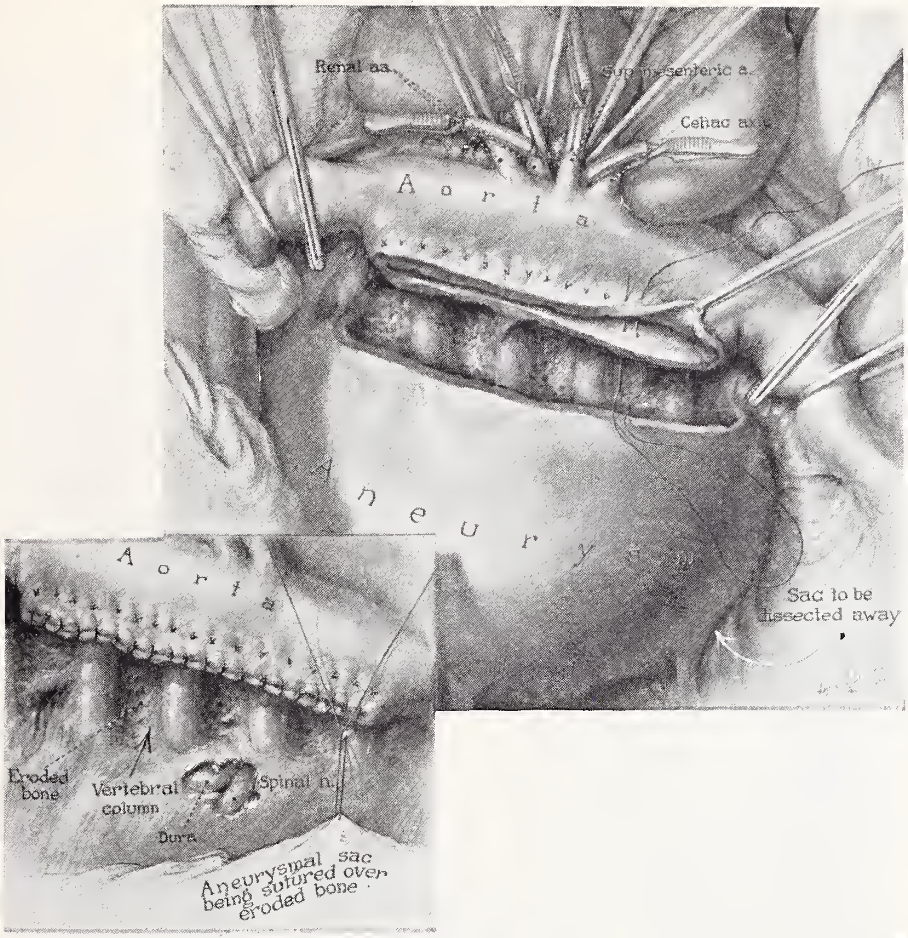

Renal aa.
Sup. mesenteric a.
Celiac ax.
Aorta
Aneurysm
Sac to be dissected away
Aorta
Eroded bone
Vertebral column
Spinal n.
Dura
Aneurysmal sac being sutured over eroded bone

FIG. 4c

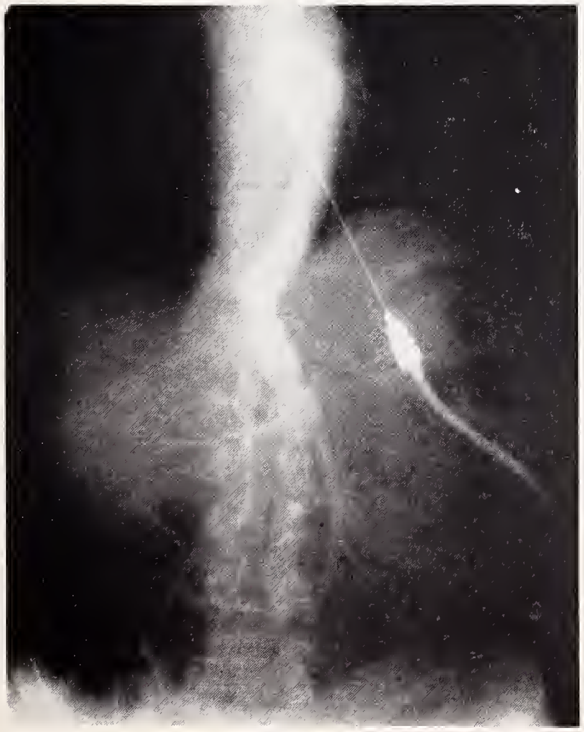


FIG. 4d

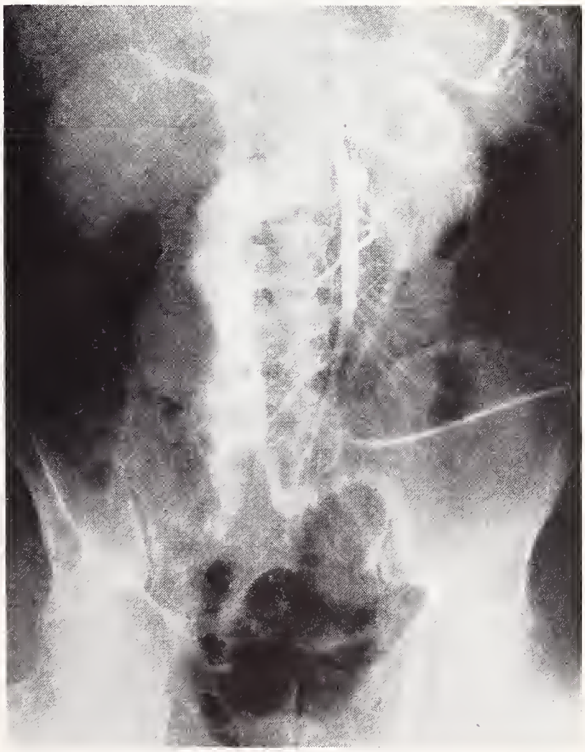


FIG. 5a. (*See page 544 for legend.*)

under observation for a probable coronary thrombosis. The mass was occasionally tender but otherwise asymptomatic. The patient was confident that it had recently enlarged. Aortography showed a slightly dilated but smooth lumen of the upper abdominal aorta. The lower abdominal aorta however was irregular. Calcium could be seen in one region and between this area and the opacified lumen represented what we thought was localized clot several centimeters thick (Fig. 5, a). At laparotomy the lower abdominal aorta from just below the renal to the external iliac arteries was involved. The entire area was excised and replaced with a graft of the same region preserved in tissue culture medium (Fig. 5, b and c). There was oliguria

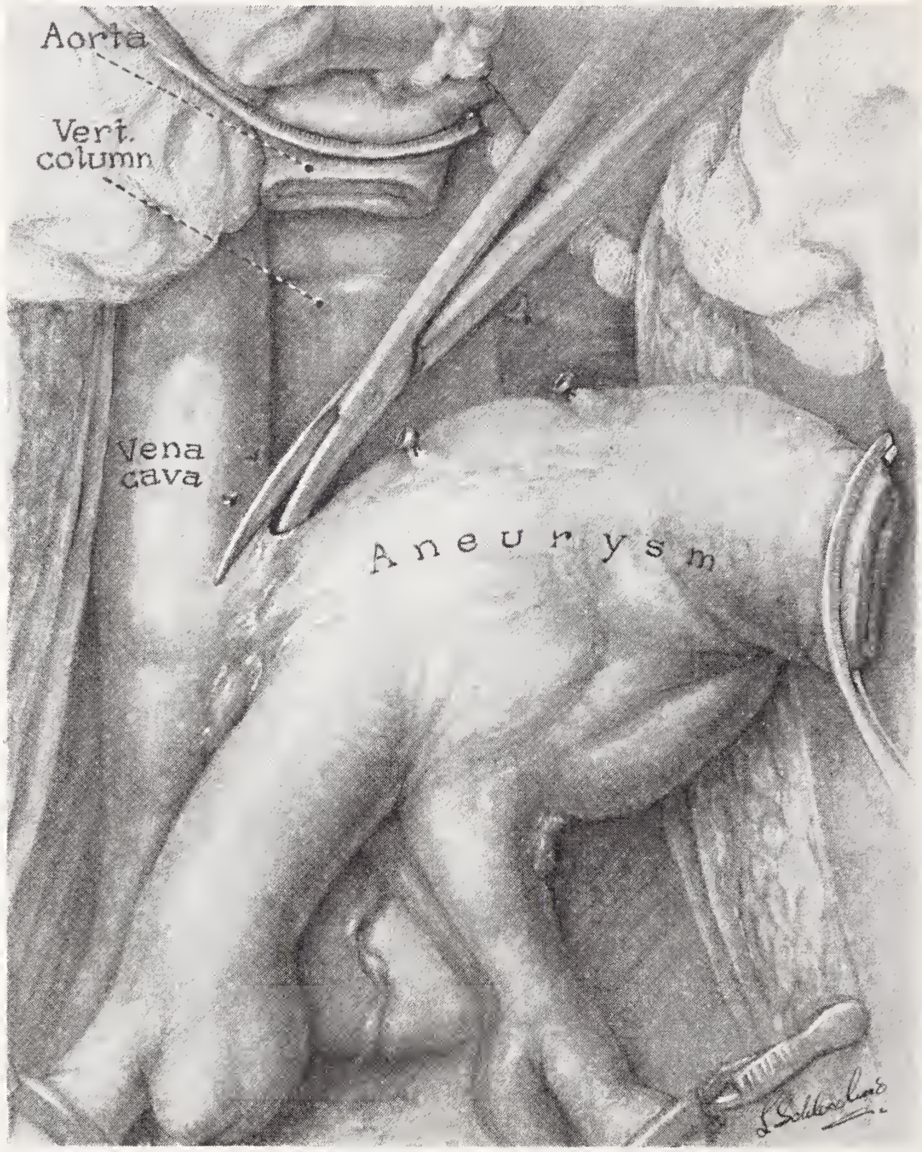


Fig. 5b

Fig. 5. A 67 year old man had an aneurysm of the distal abdominal aorta due to arteriosclerosis. It was excised and replaced by a homograft of the same region. The patient is now well.

a. Aortogram shows the irregular lower aortic lumen displaced to the right and anteriorly by localized clot.

b. The aneurysm was exposed through a long paramedian incision. The aorta and iliac arteries were occluded, and the aneurysm was excised.

c. A homograft has been sutured in place between the aorta and external iliac arteries.

during the early post-operative period but he subsequently made an uneventful convalescence.

In the past 15 months we have operated upon 20 patients with the intention of excising the aneurysm. Five of these patients died during or shortly after the operation. Of the 5 two were due to aneurysms on the ascending aorta. One of these died from a clot which was dislodged into the right internal carotid artery, and the other died from inadvertent occlusion of the left common carotid during planned occlusion of the innominate. In this the incision and exposure was limited because the aneurysm had perforated the chest wall and we were hesitant to split the sternum as has been done in other patients with aneurysms in this location. A third patient who

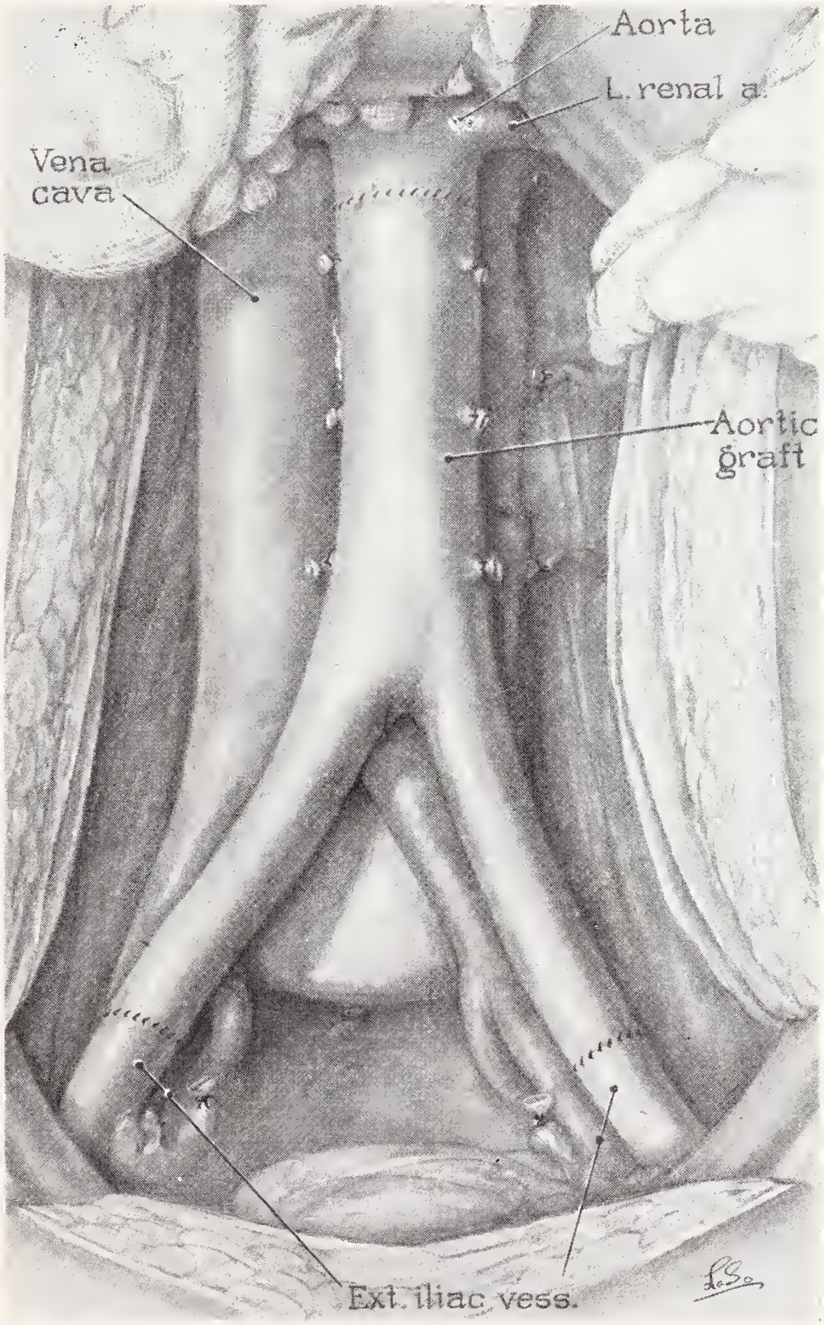


Fig. 5c

did not survive had a compound fusiform and saccular aneurysm of the entire aortic arch; we would not explore this patient at the present but at that time hoped that a saccular aneurysm in the concavity of the aortic arch could be excised with relief of his pain and respiratory obstruction. The fourth patient was a young white man without syphilis who had a large aneurysm involving the entire thoracic and upper abdominal aorta. He died the day following the excision and replacement by two thoracic aortic homografts sewed end-to-end. There was no explanation of his death other than surgical shock. The final death was for an arteriosclerotic aneurysm in a patient with an acute rupture who was in shock when the operation was begun and died before the aneurysm was excised. Of the 15 successful operations 3 patients are still in the hospital convalescing from recent operation. The other 12 are well and essentially symptom free. This group includes the patients reported in detail, one patient with an innominate and aortic aneurysm, another with an aneurysm on the ascending aorta, and one with an aneurysm on the upper thoracic aorta.

In addition to the last patient reported in detail we have successfully operated upon seven others with arteriosclerotic aneurysm in the terminal aorta. One of these was treated by aneurysmorraphy, a method which is less satisfactory than aortic homografting. One of the seven homografts was preserved in tissue culture medium. The others were frozen and dried. We are indebted to Dr. Russell Fisher and his staff for helping us procure most of these homografts. Two of the frozen dried grafts which were used were obtained from the Tissue Bank at the Naval Medical School, Naval Medical Center, Bethesda, Maryland. In four of the homografts, anastomoses were between the aorta and both iliac arteries. In one of these, done by Dr. David Sabiston, the left iliac artery was anastomosed to the side of the thoracic aortic graft: in the others bifurcation grafts were used. Three patients had excison of the terminal aorta with substitution of a segment of aorta without the branches. The only significant permanent complication in this series occurred in a patient who is still in the hospital. Occlusion of the artery in the thigh caused gangrene which required amputation of the leg. Significant oliguria occurred in two patients in the post-operative period. The others have been surprisingly free of postoperative difficulties.

In conclusion excision of aortic aneurysms has been successfully performed in all sections of the aorta and appears to be the method of choice in many instances.

REFERENCES

1. Bahnson, H. T., Definitive Treatment of Saccular Aneurysms of the Aorta with Excision of Sac and Aortic Suture. Surg. Gynec. & Obst. **96:** 382, 1953.
2. Cooley, D. A. and De Bakey, M. E., Surgical Considerations of Intrathoracic Aneurysms of the Aorta and Great Vessels. Ann. Surg., **135:** 660, 1952.
3. Estes, J. E. Jr., Abdominal Aortic Aneurysm. A Study of One Hundred and Two Cases. Circ. **2:** 258, 1950.
4. Kampmeier, R. H., Saccular Aneurysm of the Thoracic Aorta. A Clinical Study of 633 Cases. Ann. Int. Med., **12:** 624, 1938.

Figures 1 and 5 are reproduced with permission from Annals of Surgery, Vol. **138**, September, 1953.

Figures 2, 3, and 4 are reproduced with permission from Surgery, Gynecology and Obstetrics, **96:** 382, 1953.

MARYLAND RADIOLOGICAL SOCIETY

At the initial meeting of the Maryland Radiological Society, the following officers were elected for the coming year: *Chairman*, Richard B. Hanchett, Baltimore; *Vice-Chairman*, E. T. Campbell, Hagerstown; *Secretary-Treasurer*, H. Leonard Warres, Baltimore.

THE INDICATIONS FOR AND THE RESULTS OF SURGERY FOR MITRAL AND AORTIC STENOSIS*

ROBERT P. GLOVER, M.D.†

The recent "Renaissance of Cardiac Surgery" has introduced new hope and assurance both to the medical profession and to the patient suffering from the cicatricial and disastrous end results of rheumatic fever. The demonstration in the past decade that the interior of the heart could be successfully invaded at will for the reconstruction of stenotic valvular disease inaugurated this new era of surgical achievement.[1-3] Surgery, almost from its inception, has had as one of its primary objectives the relief of "obstruction and stricture" no matter where the offending block lay within the systems of the human body. It was logical, therefore, that with the application of basic surgical principles to cardiac disease initial attention and effort be directed toward the relief of "obstructed and strictured" valves.

Any consideration of valvular lesions, surgical or otherwise, must at once take into account the nature of their pathologic change. For reasons not entirely clear the valves within the heart predominantly undergo malformation according to their location within the vascular pump. Thus, the valves in the right heart (tricuspid and pulmonary) are primarily the seat of congenital deformities.[4-5] On the other hand, the mitral and aortic valves in the left heart are damaged by superimposed acquired disease, usually rheumatic in origin. Whereas, prior to 1950, the congenital anomaly monopolized the surgeon's attention, today by far the greatest field of cardiac surgical endeavor is concerned with the problems of acquired disease. Already the stage of initial conjecture and speculation as to the proper application of newly devised intracardiac surgical techniques is passing. Experience to date has shown that surgical intervention at the proper time and in intelligently selected cases can be considered a major adjunct in the overall care of the rheumatic heart crippled by valvular stenosis.[6-10]

MITRAL STENOSIS

Pathophysiology

In rheumatic disease the mitral valve develops numerous minute inflammatory verrucae in a row along the line of closure of the valve. With continuing rheumatic activity and attempts at healing over the course of years there is a gradual development of fibrosis, thickening, and narrowing of the valve leaflets as their cusp margins become adherent at the angles (commissures). This scarring may be limited in extent to resemble a purse-string puckering at the valve orifice with minimal involvement of the valve leaflets themselves, which remain quite pliable and of the consistency of kid glove skin. In other instances, the periorificial induration involves one-fourth to one-half of the valve cone leaving a correspondingly smaller margin of flexible tissue about the base at the A-V ring. In far advanced disease the whole valve may become rigid and completely inflexible—a hard, ovoid plaque surrounding a tiny fish-mouth slit. Calcium may be present at any stage as flecks, localized infiltration or, rarely, almost completely replacing valve tissue. Thus, as stenosis is produced, pronounced resistance to the passage of blood from the left atrium into the left ventricle ensues. Since the egress of blood from the left atrium is impaired, increased pressure within and considerable dilatation of this chamber results. The high intra-auricular pressure is transmitted to the entire pulmonary vascular system and thence to the right side of the heart. A chronic pulmonary hypertension results with nocturnal or exertional congestion (dyspnea), rupture of pulmonary capillaries (hemoptysis), and failure of the right side of the heart (hepatomegaly, ascites, and peripheral edema).

---

* Presented at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, Tuesday Morning, April 28, 1953, Osler Hall, Baltimore, Maryland, under the title, "Indications and Results in Cardiac Surgery."

† Clinical Professor of Thoracic Surgery, Hahnemann Medical College and Hospital. From the Thoracic Surgical Services of Hahnemann, Episcopal, Presbyterian and Lankenau Hospitals, Philadelphia, Pennsylvania.

Once this progressive pattern becomes heralded by the onset of fatigue and exertional dyspnea the ultimate outcome for the patient is in time invariably unfavorable. At this point the treatment of the physician will be directed toward the support of a myocardium which is vainly attempting to maintain an adequate systemic circulation in the face of an unrelenting mechanical stricture. The fort can be held temporarily but eventually under such circumstances both the physician and the myocardium are fighting a losing battle. It is paramount to recognize that the earliest onset of symptoms bespeaks a failing myocardial and pulmonary vascular reserve as the result of *already long-standing structural valvular stenosis*. To repeat, with the onset of symptoms the valvular lesion for the most part has already reached its ultimate cicatrix and progression of the patient's disability is one of symptomatic breakdown and disintegration, not of increasing structural stenosis within the valve itself. The therapeutic conclusion is obvious. The stenotic valve must be opened at the earliest suggestion of the above described obstructive phenomena if one is to avoid the inevitable progression of enlarging cardiac chambers (left atrium, right ventricle, right atrium), pulmonary edema, recurrent hemoptysis, auricular fibrillation, embolic episodes, and chronic congestive (right heart) failure.

Clinical Classification

The following classification has been prepared to provide a clinical, functional yardstick paralleling the progressive pathophysiologic changes as outlined above.

Stages of Mitral Stenosis

I. Asymptomatic
II. Statically incapacitating
III. Progressively incapacitating
IV. Terminally incapacitating
V. Irretrievable

Stage one includes those with the auscultatory findings of mitral stenosis but who as yet have no symptoms. Cases in *stage two* have progressed to the point at which dyspnea and fatigue under physical stress have developed but the patient, with or without medication, living within his own limitations remains on an even plateau. *Stage three*, inevitably the largest group and one encompassing many variables, includes those who, despite the best medical therapy, are slowly losing ground, i.e., are faced with increasing reliance upon diuretics, daily bed rest, etc. In *stage four*, terminally incapacitating, are those patients in whom there is constant evidence of congestive failure even with reasonably limited physical activity. Most of these can be rendered relatively free of their accumulating tissue fluid only by the strictest of medical regimens, including constant rest in bed. Even then, not infrequently, one is unable completely to reduce hepatic congestion. A certain small percentage of those in this group will ultimately prove after surgery to have been in *stage five* and to have had irreversible pulmonary arteriolar changes. As yet, it has been impossible routinely to separate patients in these two stages by clinical and physiologic methods now available hence we reserve *stage five* to classify those who, despite a technically adequate commissurotomy, receive no improvement because of irreversible cardiopulmonary pathologic change.

Surgical Objective

It is sufficient to state here that mitral commissurotomy is a procedure in which the individual anatomic leaflets of the stenotic valve are separated. By incising the angles or commissures of the mitral slit, its obstructing effect can be overcome and a considerable degree of valve function can be reestablished. It is to be noted that no valve tissue is removed, thus allowing the liberated though thickened and deformed valve leaflets to open during ventricular diastole and approximate during ventricular systole without the production of additional significant regurgitation (Fig. 1).

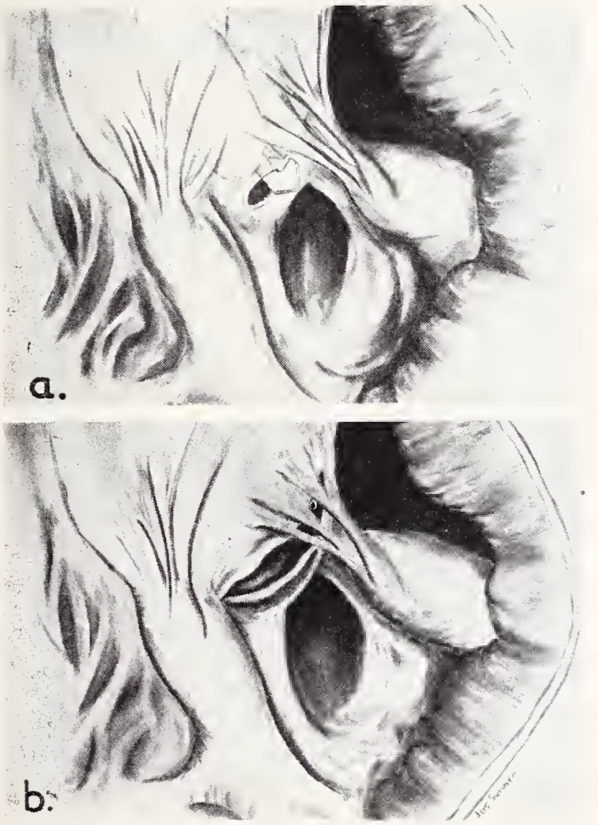


FIG. 1. A. Left ventricular view of the mitral valve cone in stenosis. The right index finger and Glover-Avery guillotine have been inserted through the left auricular appendage and properly placed for incision of the anterolateral commissure. B. Valve orifice after commissurotomy. Note the intact chordae tendineae insuring partial restoration of valve function with prevention of significant mitral insufficiency.

Indications for Commissurotomy

In the light of the foregoing presentation, the selection of patients for surgical intervention can be simply stated. The *ideal candidate* is the patient with pure mitral stenosis and beginning symptoms of cardiopulmonary dysfunction such as shortness of breath upon exertion. Fatigue out of all proportion to the patient's physical activity is frequently a prodromal or accompanying finding. The mere presence of a well defined mitral diastolic murmur without accompanying symptoms is insufficient reason to suggest surgery, for the operation is not performed primarily because of the murmur but to improve the patient's functional status.

All other indications for commissurotomy are merely compromises from the ideal but for years to come an understanding of the more advanced but altogether salvable states is essential. An outline under seven major categories will most succinctly serve this purpose:

1. History
    a. Early cardiopulmonary dysfunction—ideal.
    b. Marked dyspnea, hemoptysis, reversible failure—acceptable.
2. Age: Elastic range—physiologic rather than chronological. (Oldest age 61)
3. Valvular defect.
    a. Pure mitral stenosis—ideal.
    b. Associated mitral insufficiency and/or aortic valve lesion in presence of normal left ventricle—acceptable.
4. Roentgen findings.
    a. Left atrium and right ventricle minimally enlarged—ideal.
    b. Minimal left ventricle enlargement—questionable but acceptable.
5. Electrocardiogram.
    a. Normal electrical axis or right ventricular strain—ideal.
    b. Left axis shift—never acceptable.
    c. Auricular fibrillation with controllable ventricular response—acceptable.
6. Functional capacity.
    a. Stage 2 (statically incapacitating)—ideal.
    b. Stage 3 (progressively incapacitating)—acceptable.
    c. Stages 4 and 5 (debatable)—occasional good result.
7. Complicating factors.
    a. Arterial embolic episodes
    b. Recurrent hemoptysis } Acceptable, and may be urgent.
    c. Pregnancy
8. Contraindications.
    a. Acute rheumatic fever.
    b. Subacute bacterial endocarditis until controlled.
    c. Associated marked mitral and aortic insufficiency with all cardiac chambers enlarged.

Analysis of Cases

Five hundred mitral commissurotomies have been performed by the author and his partner, Dr. Thomas J. E. O'Neill. The operative mortality rate for the entire series has been 5.9%. A statistical breakdown of the first 164 of these cases in whom complete data to the present day is available (2 to 4½ years) can be seen in table 1. It will be noted that no cases have been attempted in Stage 1, and this is as it should be in the present state of such a program. The operation should not be undertaken on the basis of a murmur alone, but for the relief of the patient's functional deterioration of which the murmur is but an auscultatory incident. However, many more than have been in the past should be referred for surgery when in Stage 2 for by this time it is obvious that myocardial strain and ultimate breakdown is at hand. Stage 3 represents an imperative indication beyond which the patient under good care should not be permitted to progress. Stages 4 and 5, frequently undistinguishable clinically, represent pure salvage on a calculated risk basis and should be subjected to surgery only with the patient's full knowledge and understanding of the risks involved.

TABLE 1

Mitral Stenosis

STAGE OF STENOSIS	NO. CASES	DEATHS		MORTALITY %	
		Operative	Late	Operative	Late
I. Asymptomatic	0	0	0	0	0
II. Statically Incapacitating	14	0	0	0	0
III. Progressively Incapacitating	105	5	1	4.7	.9
IV. Terminally Incapacitating	32	3	0	9.3	0
V. Irretrievable	13	2	8	15.3	61.5
Total	164	10	9	6.1	5.5

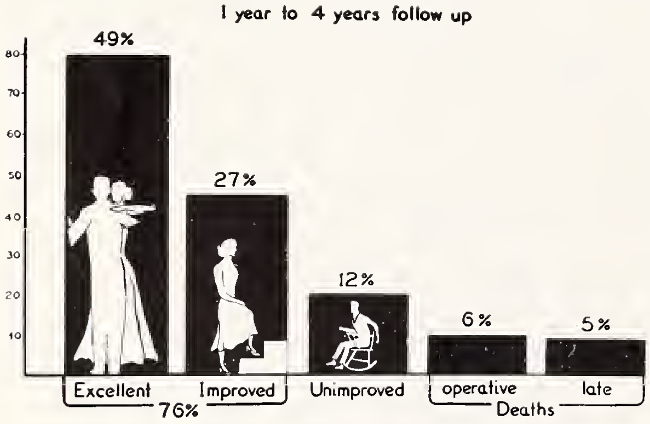


FIG. 2. Results of Mitral Commissurotomy

The results, as graphically portrayed in Figure 2, are self-explanatory. Excellent (49%) means that the patient has been restored to a normal, productive life, enjoying normal activities without obvious limitation. A low salt diet and mercurial diuretics are no longer necessary. Most of these have dispensed with the use of digitalis. 27% are classified as improved in that they are objectively and subjectively better as evidenced by their return to almost normal life and activity. Most are under partial medication (digitalis) because of the demands of their more greatly enlarged sphere of activity. A few, terminally incapacitated before surgery, have now become so amenable to therapy that reasonable activity requires digitalization only. The range of improvement in this group varies widely with the condition of the valve found at surgery and the degree to which valve function could be restored. Their progressively downhill course has been abruptly terminated or reversed, some to regain a high level of efficiency and others to remain on an improved plateau.

Twenty patients (12%) have been essentially unimproved. Multivalvular disease and significant mitral insufficiency, the extent of which was not entirely appreciated until valve exploration, were the major causes for the unsatisfactory outcome.

The operative mortality in the 164 cases closely parallels the mortality in the entire series and was 6.1%. As might be expected, the deaths occurred in the more advanced stages of the disease (Table 1), and were due primarily to the unyielding nature of the valvular pathology or to improper technique as applied to the pathologic state present (operative, anesthetic and diagnostic). The late deaths were all occasioned by the presence of pre- and postoperative irreversible cardiovalvular and pulmonary-hepatic vascular (and parenchymal) disease which remained unaffected by the mere relief of mechanical obstruction and progressed to their normal termination.

Aortic Stenosis

The problems associated with the surgical alleviation of aortic stenosis have to date presented far greater difficulties than any of the other stenotic valvular lesions. There are a number of reasons for this.

Anatomically, the valve is the least accessible to exploration, for it lies centrally placed within the confines of the heart. In aortic stenosis, the left ventricular myocardium is greatly hypertrophied, which, together with the tremendous vascular pressure generated within its outflow tract, prevent the use of a subaortic transmyocardial incision for the insertion of finger or instrument similar to that used in pulmonary valvulotomy, because of the ensuing uncontrollable hemorrhage. The valve cannot be effectively reached through an auricular appendage. The position of the ostia of the coronary vessels lying directly behind the valve leaflets makes direct reconstructive surgery hazardous.

Pathologically, there is an early fusion of the three valve cusps, the margins of which become thickened, rolled, eburnated and infiltrated with calcium very early in the course of the disease. This is due, in part, to the disease itself but more particularly to the location of this valve in the course of the blood stream. The valve lies in a confined space of small diameter and is the recipient of the full head of vascular pressure from the strongest of contracting cardiac chambers—the left ventricle. The factor of vascular *trauma* is, therefore, of great importance for, following initial fibrotic agglutination of the cusp margins, there is a constant and steady deposition of traumatic elements such as fibrin and calcium from which there can be no relief. Thus, calcification develops early and as the leaflets are relatively small in surface area, almost complete immobility and fixation may be rapidly evident. Some flexibility of the cusps at their attachment to the aortic ring may remain for a time but this is less prominent than that seen in the stenotic mitral valve. This factor of *trauma* no doubt partially explains the fact that the antero-medial leaflet of the mitral valve (also called the aortic or septal leaflet) is the seat of the greatest calcification in mitral stenosis, for it lies nearest the aortic ring in the high pressure left ventricular outflow tract and also received the brunt of the vascular ejection at the time of left ventricular contraction. Therefore, from a pathologic standpoint, surgical intervention in aortic stenosis, to effectively restore a measure of normal valve leaflet motion, must be carried out before extremes of the above described process are reached. To wait longer merely compounds the likelihood of surgical failure, for in consequence of the valvular change the left ventricular myocardium hypertrophies and dilates, in due time to wear out and become incapable of effective action. As the left ventricle is the cornerstone of the heart and circulation its failure predicates irremedial disaster. This is in contrast to the findings in mitral stenosis, where, despite profound pathological and clinical changes even to the point of prolonged congestive failure and invalidism, the left ventricle retains its indispensable function—actual, compensatory and recuperative—almost to the end.

Physiologically, because of the jet-like ejection of relatively small amounts of blood with each left ventricular contraction, the systolic blood pressure may not reach high levels although it is perhaps sustained and maintained longer than usual. Diastolic pressures, however, are high so that the pulse pressure is small and coronary artery filling, now under greater stress because of the demands of an increased myocardial mass, may be inadequate. As such, these patients are often precarious anesthetic risks, to say nothing of the superimposed danger of surgery.

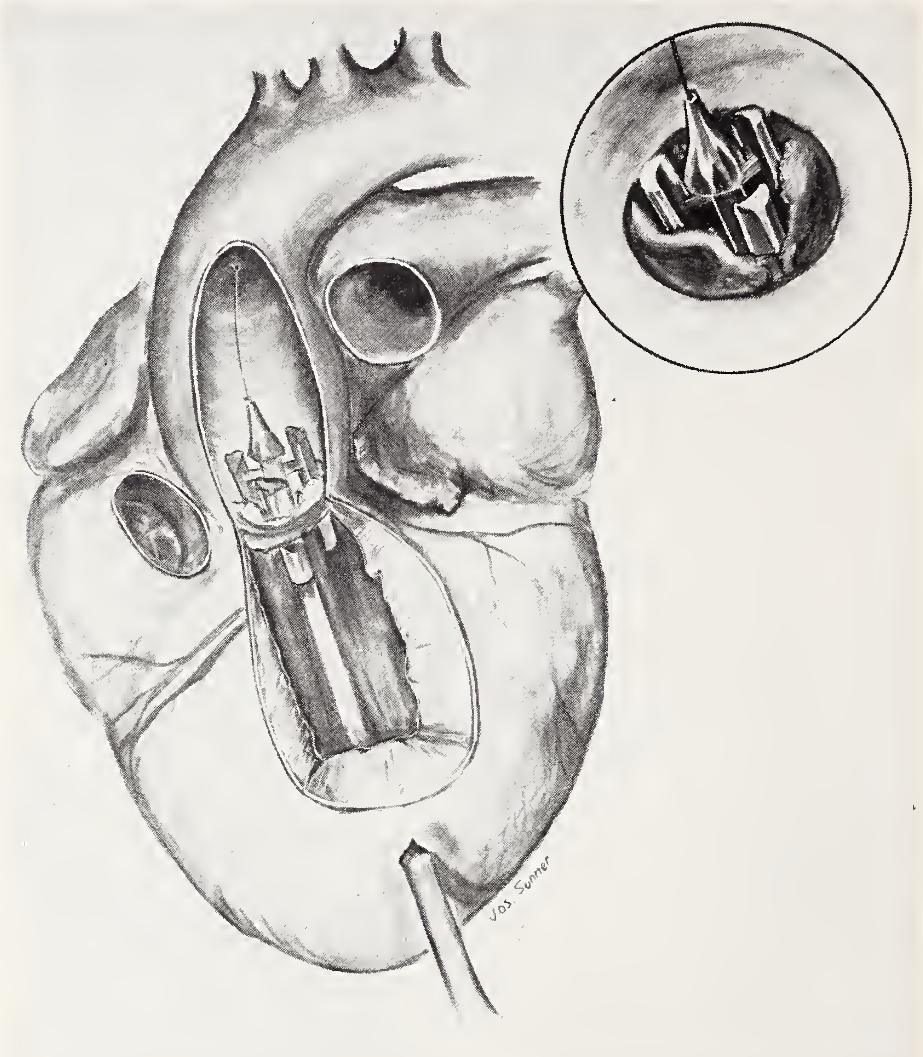


Fig. 3. The aortic dilator inserted through the myocardium of the left ventricle near its apex. This instrument is guided through the aortic valve by threading it over a fine olive-tipped wire previously placed through the valve. *Inset.* The three flanges of the dilating head separating the commissures. The self-rotating head settles automatically into the V-shaped commissures of the fused aortic cusps.

Surgical Objective

Despite these apparent roadblocks, considerable progress has been made. The experimental work which has been undertaken in an effort to find a satisfactory surgical solution to this problem has been previously reported.[11] Briefly, the present operative approach calls for a left lateral thoracotomy, the introduction of a dilating instrument through a relatively avascular area of the left ventricle near its apex and lateral to the left descending coronary artery. The dilator is directed through the valve by passing it over a previously placed wire guide, the olivary tip of which can be felt in the aorta prior to the insertion of the larger instrument through the myocardium. The dilating head opens in triangular fashion causing the fused commissures of the stenotic valve to separate, partially relieving the stenotic obstruction and restoring a measure of valve action (Fig. 3).

Clinical Classification

The necessity for translating the present rationale of surgery for aortic stenosis into reasonable, practical language has called for the development of a classification for the recognition of clinical states either applicable or unsuitable for surgery at the present time.

The recognizable clinical stages through which the average patient with aortic stenosis will pass are well known, although perhaps not readily defined in the mind of the physician in the light of surgical advances. Stage 1 is the period during which the typical systolic murmur develops before symptoms result. Stage 2 marks the onset of an ill-defined period where the patient becomes subjectively aware of his forceful heart action, palpitations develop, easy fatigue becomes noticeable and his attention may be called to the unusual, visible pulsations in his supraclavicular and suprasternal notches. Admittedly, this stage is not specifically characteristic of aortic stenosis per se, but when seen with an aortic systolic murmur the combination takes on added significance. Stage 3 ushers in the obvious period of progressive disability due to a diminishingly effective cardiac output as evidenced cerebrally by spells of dizziness and actual syncope. Myocardially, substernal discomfort, tightness, effort angina with its characteristic distribution bespeaks of inadequate coronary flow. With beginning left ventricular failure, Stage 4 is characterized by episodes of pulmonary congestion and edema at first rather easily controlled by medical measures but shortly to become refractory to even the most vigorous management. Stage 5 connotes impending disaster and an early demise for right heart failure with hepatomegaly, ascites and peripheral edema labels the heart picture as one of irretrievable damage not to be reversed by any regime—medical or surgical.

Table 2

Aortic Stenosis

STAGES	RESULTS				
	No.	Excellent	Improved	Unimproved	Deaths
I. Asymptomatic—murmur only	0	—	—	—	—
II. Fatigue, Heart Consciousness, Palpitations	2	2	—	—	—
III. Syncope, Angina	10	2	6 (3*)	1	1
IV. Episodic Pulmonary Congestion	5	—	3	1	1 (1*)
V. Congestive Failure	5	—	—	—	5 (2*)
Totals	22	4	9	2	7

* Combined mitral and aortic commissurotomies.

Results of Surgery (*Table 2*)

Twenty-two cases have undergone aortic commissurotomy and six of these have been combined with a mitral commissurotomy because of concurrent bivalvular stenosis. One patient (Stage 2) done over three years ago remained completely asymptomatic for two years. During the past 12 months, although working steadily and living a normal life, he has noticed some minor precordial tightness with exercise after meals which had not been present during his first two postoperative years. This patient's aortic commissurotomy was performed with our original dilator[2] which did not have the strength or wide diameter opening of the present more refined instrument which may account for his present status. Clinically there has been no change in his cardiac findings.

The remaining twenty-one cases have been operated upon in the past eighteen months. The pertinent data can be seen at a glance in table 2. The overall mortality has been high which may have been influenced somewhat by the inclusion of cases with bivalvular surgery. The observation of paramount importance, however, is that cases done in the early symptomatic phase (12 cases—Stages 2 & 3) run a risk of only 8.3% and even including those in Stage 4, when pulmonary edema has entered the picture the mortality rate is a reasonable 11.7%. One has only to consider the seriousness of the disease and the utter hopelessness of its immediate prognosis to appreciate that such results are highly encouraging at this stage of our surgical programme. When true congestive failure has developed (Stage 5) it is doubtful whether much, if any, salvage can be either expected or obtained.

CONCLUSIONS

The natural course and progression of rheumatic stenotic valvular disease has dictated the necessity for the mechanical relief of its acquired stricture. Mitral and aortic commissurotomy have become major adjuncts in the overall and continuing care of victims so afflicted. Provided the patient is referred for surgical intervention early in the course of his symptomatic progression, such a patient can be restored to a high level of efficiency and enjoy a more normal life as a useful and productive citizen. The burden of selecting patients at *an early stage* rests squarely on the shoulders of the practicing physician and this responsibility can no longer be avoided or postponed.

BIBLIOGRAPHY

1. Bailey, Charles P.; Glover, Robert P., and O'Neill, T. J. E.: Surgery of Mitral Stenosis, J. Thoracic Surg. **19:** 16–49 (January) 1950.
2. Glover, Robert P.; Bailey, Charles P., and O'Neill, T. J. E.: Surgery of Stenotic Valvular Disease of the Heart, J.A.M.A. **144:** 13, 1049–1057 (Nov. 25) 1950.
3. Glover, Robert P.; O'Neill, T. J. E., and Bailey, Charles P.: Commissurotomy for Mitral Stenosis, Circulation **1:** 329–342 (March) 1950.
4. Glover, Robert P.; Bailey, Charles P.; O'Neill, T. J. E.; Downing, D. F., and Wells, C. R. E.: The Direct Intracardiac Relief of Pulmonary Stenosis in Tetralogy of Fallot, J. Thoracic Surg. **23:** 1, 14–41 (January) 1952.
5. Glover, Robert P.: Stenotic Valvular Disease of the Heart: Surgical Treatment, Texas State Journal of Medicine **48:** 674–685 (October) 1952.
6. O'Neill, T. J. E.; Glover, Robert P., and Bailey, Charles P.: Commissurotomy for Mitral Stenosis, J. Internat. Coll. Surgeons **13:** 355–360 (April) 1950.
7. O'Neill, T. J. E.; Glover, Robert P., and Bailey, Charles P.: Observations on Surgical Treatment of Mitral Stenosis by Commissurotomy, J.A.M.A. **147:** 1032–1033 (November 10) 1951.
8. Glover, Robert P.; O'Neill, T. J. E., and Bailey, Charles P.: Mitral Stenosis, Its Surgical Treatment by Commissurotomy, Pennsylvania M. J. **53:** 375–384 (April) 1950.
9. Janton, O. Henry; Glover, Robert P., and O'Neill, T. J. E.: Results of the Surgical Treatment of Mitral Stenosis (Analysis of 100 Consecutive Cases). Circulation **6:** 321–333 (September) 1952.
10. Glover, Robert P.; O'Neill, T. J. E.; Harris, James S. C., and Janton, O. Henry: The Indications for and the Results of Commissurotomy for Mitral Stenosis. J. Thoracic Surg. **25:** 1, 55–77 (January) 1953.
11. Bailey, Charles P.; Glover, Robert P.; O'Neill, T. J. E.; and Redondo-Ramirez, R. P.: Experiences with Experimental Surgical Relief of Aortic Stenosis; Preliminary Report, J. Thoracic Surg. **20:** 516–541 (October) 1950.

SOUTH DAKOTA STATE BOARD OF MEDICAL EXAMINERS

John C. Foster*

The South Dakota Board of Medical Examiners has announced the passage of legislation creating an annual registration fee for licencees in that state in the amount of $2.00. The registration takes effect January 1, 1954. If you are licensed in South Dakota and wish to maintain that license by payment of the registration fee, please contact the South Dakota Board of Medical Examiners, 300 First National Bank Building, Sioux Falls, South Dakota.

* John C. Foster, Executive Secretary.

THE NON-OPERATIVE TREATMENT OF STRESS INCONTINENCE IN WOMEN*

LAWRENCE R. WHARTON, M.D.†

Stress incontinence is a relatively common complaint among women. Gynecologists have also found it a difficult problem to understand and treat. This is true today in spite of the fact that during the past fifty years, this problem has been studied from every conceivable angle.

Among modern gynecologists, Dr. Howard A. Kelly was a pioneer in these investigations. In 1914, in conjunction with William Dumm, he published an article on this subject in which he attributed the incontinence to weakness of the internal sphincter of the urethra and described the operation, plication of the internal sphincter. At that time he stated that he had been studying the problem for many years and that he had been using this operation with a considerable degree of success for 10 years. That procedure has become one of the standard methods of treating this condition.

Since that time, interest in this syndrome appears to have increased with passing years. This has been directed generally into two main channels—study of the anatomic and physiologic factors that may have any bearing on the incontinence and the discovery and modification of new operations devised to correct it. Needless to say, an immense amount of time and energy has been expended in these efforts.

In spite of all of this, as Berkow stated in February, 1953, "the physiological mechanism of urinary control in the female has remained obscure" and most of us will agree with the conclusion of the London conference of 1950, quoted by Berkow, that the "exact mechanism of stress incontinence is not completely known."

A similar uncertainty marks the surgical efforts to cure this condition. For many years, the Kelly plication of the vesical sphincter remained the operation of choice. It is still the author's preference, under ordinary conditions. In 1947, TeLinde published a follow-up study of 249 cases in which this procedure had been performed in the decade preceding 1947. He reported that 90.3 per cent had been cured, 5 per cent improved, 3.5 per cent failed and 1.2 per cent were not traced. This report is a little more favorable than my own personal experience, and could not represent the general opinion, because, according to Marchetti, 95 different surgical procedures have been devised and reported in the literature to correct stress incontinence, many in the last few years. Some of these procedures, unlike Dr. Kelly's, are difficult technically, and occasionally have been followed by sequelae such as fistulas and strictures which were worse than the original condition.

A new idea was introduced into this confused situation in 1949 when Kegel suggested the use of exercises for the relief of stress incontinence. He published a second paper on this subject in 1951. As far as we know, this was the first time that this form of treatment was used in this condition in women, although urologists tell me that they have been using it for many years to improve urinary control after prostatectomy and other operations on the male urethra. Likewise, rectal surgeons have been using these exercises after operations upon the rectal sphincters. Kegel reported remarkable success in his cases of stress incontinence, and this stimulated me to study the problem in my own private practice.

This report is based on the cases of stress incontinence that I have seen, mostly in the past three years. It also includes two ward cases treated by the resident staff of the Johns Hopkins Hospital and one treated by the residents of the

---

* Presented at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, Wednesday Afternoon, April 29, 1953, Osler Hall, Baltimore, Maryland.

† Assistant Professor of Gynecology, The Johns Hopkins University School of Medicine, Baltimore, Maryland.

Women's Hospital. This series includes 60 cases; this report, however, is based on the first 40.

In all of these women, stress incontinence was a major complaint. They were all subjected to a complete gynecological study and any other indicated investigations. It was my object to try to discover any factors that were associated with the stress incontinence, to try to correct them when possible and to observe the effect of this therapy on urinary control. It was my particular desire to try to discover whether non-operative measures, especially exercises, were helpful in this condition. We shall first summarize the clinical data discovered in these cases.

CLINICAL DATA

There is nothing new or startling in these clinical facts.

Age. Although stress incontinence may develop in early life, 75 per cent of our cases were between 40 and 60 years of age. Two were over ninety years old; two between twenty and thirty.

Marital. Thirty-seven of these women were married; three were single.

Parity. Thirty-three had borne children; seven had never been pregnant.

DURATION OF INCONTINENCE

0–1 year	6 cases
1–5 years	9 cases
5–10 years	4 cases
10–20 years	9 cases
20–30 years	4 cases
30–40 years	4 cases
More than 40 years	2 cases

ASSOCIATED DISEASES OF THE URINARY TRACT

In 10 patients, 25 per cent, there were the following urological disorders:

Urethral caruncle	1
Urethritis and trigonitis	4
Chronic cystitis	3
Chronic pyelitis and hydronephrosis	2

These conditions were all treated and were corrected, with the exception of one case of infected hydronephrosis with recurring acute pyelitis, which was only improved. In none of these cases, however, was the stress incontinence completely cured by the elimination of the urological disorder. In all but two, however, the stress incontinence was definitely improved and control was better after the urological condition had been corrected. In two, a patient with urethral caruncle and another with chronic cystitis, the control was no better after than before the urological treatment.

From this, it is clear that the elimination of a urological disorder is helpful in correcting stress incontinence, on the basis that a normal urinary tract will function better than a diseased one. In all but two of these cases, even better control was obtained by the use of exercises after the urological treatment had been completed.

Strong, of Philadelphia, has reported better results than this, following the elimination of urologic disorders in women with stress incontinence—(In Discussion of paper in Journal of Urology, April, 1953.) There will be percentage differences in all such reports; the basic fact remains that in stress incontinence in women, it is advisable to make careful urologic studies when indicated, and to restore the urinary tract to normal before expecting much relief in urinary control.

GYNECOLOGIC DISORDERS FOUND IN CASES OF STRESS INCONTINENCE

In this series there were 14 cases showing various degrees of pelvic relaxation or prolapse. There were eight cases of complete prolapse of the uterus and vagina, and six with cystocele and rectocele.

In twelve of these cases of complete prolapse, the procidentia had been cured by appropriate surgical procedures. These operations had been performed by various gynecologists, chiefly in Baltimore. These patients continued to have stress incontinence, after having been cured of prolapse. We have frequently heard that in stress incontinence, associated with prolapse, one need only correct the prolapse, restore adequate subvesical support and the stress incontinence will then disappear spontaneously. This is undoubtedly true in many cases; in some, however, it is not the case, as this series shows.

In only four of these twelve, had any particular effort been directed toward correcting urinary control, and in these Kelly plication of the sphincter had been carried out in addition to the operation for prolapse. In three of these, the control had been improved; in one, there had been no improvement.

In these 12 women who still had stress incontinence after having been cured of uterine prolapse, we suggested exercises. Not all of them co-operated, but of the twelve, 5 were completely cured of stress incontinence and one was improved by exercises.

In this group with prolapse and stress incontinence, two were not operated upon. One was rather elderly, 74 years old, with complete procidentia, a ward patient in the Women's Hospital. While she was in the hospital, being studied preoperatively, she had a coronary thrombosis. This completely eliminated all further consideration of surgery. Since her main complaint had been stress incontinence, the resident staff gave her a course of exercises, which restored complete urinary control. In the second case, also, one of cystocele and rectocele, the main complaint had been stress incontinence. As a preoperative measure, exercises proved so successful that the patient has not been operated upon for the cystocele and rectocele.

Postoperative Stress Incontinence

This series includes three cases of postoperative stress incontinence; two developed after vaginal hysterectomy for prolapse, and one developed after a Manchester operation. In none had it been present before the operation.

One of these cases is rather unusual in that she developed stress incontinence after each of two operations for prolapse and recovered complete control without any further treatment at all. The first time, stress incontinence appeared after a vaginal hysterectomy performed elsewhere; it lasted one year and then disappeared spontaneously. Unfortunately, however, the vaginal hysterectomy was followed by vaginal prolapse, without any urinary symptoms. I operated upon her on the second occasion in 1949, and she again developed stress incontinence, which again disappeared spontaneously in one year. So far the prolapse has not occurred.

In the second case which developed after a vaginal hysterectomy, the patient did not try the exercises and still has stress incontinence. In the third case, which developed after a Manchester operation done by me, the stress incontinence disappeared completely after three weeks of exercises.

This group of cases of stress incontinence associated with prolapse or cystocele, leads one to suggest that stress incontinence is not always dependent on uterine prolapse, that a person may have complete prolapse without any stress incontinence, and that with or without prolapse, stress incontinence may occasionally be cured by strengthening the perineal and sphincter muscles by exercises. These data are susceptible of various interpretations.

Stress Incontinence and Vesico-Vaginal Fistula

This association has been seen in one instance. In 1951, a 37 year old woman developed a vesico-vaginal fistula after an operation for a urethral diverticulum. This fistula persisted after the first operation to cure it; following this, she was sent to Baltimore and admitted to the Johns Hopkins Hospital as a ward patient. The resident gynecologist found not only a small vesico-vaginal fistula but also a weak vesical sphincter with stress incontinence. He closed the fistula and did a Kelly plication of the vesical sphincter. The fistula operation was a complete success, but the patient was almost as incontinent as ever, because of the failure of the sphincter operation. The resident therefore gave her urethral exercises, and since 1951, she has had excellent urinary control.

GENERAL FACTORS

Obesity. Fifteen of these 40 incontinent women were more or less obese. In all of these women, we tried to interest them in diet control and weight reduction, usually with no success. In some instances, however, we have felt that part of the success of the treatment of stress incontinence was due to weight reduction.

Neurological disorders. An excellent operative result in stress incontinence may be completely vitiated by the development of a serious neurological disease. This happened to two of our patients, in whom excellent results had been obtained by Kelly plication followed by exercises. These patients later developed both rectal and urinary paralysis, in addition to mental changes as the result of serious central nervous system disease. Neurological examinations are always indicated in certain cases of stress incontinence, before starting any course of treatment.

Psychic instability. Experience teaches us that urinary control is affected by nervousness, even in normal women. When there is a weakness of the vesical sphincter or the control mechanism is somewhat impaired, nervous and psychic instability may also upset urinary continence. One of our patients has stress incontinence only while in Baltimore, in the midst of her domestic and business disturbances—while away from town she has perfect control. Other women state that excitement is just as effective as coughing or sneezing in producing incontinence. This is therefore a factor to be considered.

THE TYPE OF EXERCISE USED

It is basically important that the patient understand what she has to do. In spite of all our explaining, we have found that some women have failed utterly to comprehend the situation.

The exercise is simply the same contraction that one makes when stopping the flow of urine. It is the same effort that one makes voluntarily to prevent the flow of urine, when the desire to void appears under unpropitious circumstances. At the same time, one often contracts the rectal sphincter and perineal muscles.

This is the exercise the patient is to perform. She is told to contract the urethral sphincter in this way 15 times in the morning, 15 times at noon, and 15 times at night. She may also perform this exercise as often in addition as she wants to. She should do this for at least one month—the average case will show improvement before that.

The perineometer. I have not found the perineometer necessary. Kegel has used it almost routinely, but we have never used it. It would seem to us an unnecessary encumbrance that would prevent the use of exercises except at home. It would also greatly complicate the performance of simple exercises. Furthermore, our results without the perineometer have been about the same as the best results obtained with it. We see no reason, however, for withholding its use in any case where it would appear desired or advantageous.

SUMMARY OF RESULTS

Following the various non-operative methods of treatment outlined previously in 33 cases, 11 have been cured, 13 improved and 9 unimproved.

Cured	11 cases	33%
Improved	13 cases	39%
Unimproved	9 cases	27%

Since in this situation, the result is based entirely on the functional result and is determined by the patient herself, the definition may not be as sharp as we would like. We have listed as cured only those who state that they have had no incontinence since using the exercises. The other terms are more or less self-explanatory. However, in our experience there is apt to be some lack of permanency in the definitions between these groups, in that a woman who may be perfectly continent for months may, under nervous or physical strain, have a recurrence of stress incontinence. We have seen this several times; almost invariably these patients resume exercises for a few weeks with good results.

Types of treatment used. In this group we have used only non-operative measures. In 10 of the 33 patients, *urological disorders* were discovered and treated, with improvement in the stress incontinence in all but 2. After the urinary disorders had been corrected, the use of exercises gave even better or perfect urinary control. In other words, normal urinary control is more easily obtained with a normal urinary tract.

Other factors that have contributed to stress incontinence have been treated. This includes obesity, nervousness, gynecological, psychiatric and neurological disorders. It is our impression that the elimination of any associated factor will definitely aid in recovering urinary control and contribute to its permanence.

In practically all of these cases, exercises were used to complete the treatment and supplement the benefit that may have been obtained by other means.

On the basis of this and subsequent experience, we have the general impression that a perfect result obtained surgically by the Kelly plication operation or any other surgical means, is more apt to be permanent than an equally good result obtained by exercises. However, in both groups, an excellent result may be completely ruined by subsequent developments such as neurological diseases or an intractable cough due to asthma or chronic bronchitis.

Causes of Failure

In analysing the cause of failure in 9 cases, we find the following: Senility, failure to perform the exercises, neurological disease, nervousness and psychic instability and coughing due to asthma and bronchitis.

Kegel pointed out the fact that senility and chronicity were unfavorable factors; that applies whether the stress incontinence is treated by surgical or non-operative measures. One of our failures following non-operative care, was in a spinster over 90 years old; another in a woman over 75. It is difficult to get a woman 90 years old to perform exercises or alter a situation which has existed for decades, regardless of how inconvenient it may be.

Five women did not attempt the exercises at all. Some were fairly young and were apparently too lazy to do anything for themselves. In others, failure to cooperate was understandable because of their senility.

In two women, results that had been satisfactory were completely ruined by the development of organic paralysis of the rectal and urinary sphincters. Both of these women had had Kelly plications may years previously with subsequent recurrence of stress incontinence, which had been relieved by exercises.

The development of unusual stress or strain may likewise overcome a good result, either surgical or non-operative. In two of our cases that had been considered cured of stress incontinence by exercises, the development of asthma and chronic bronchitis with uncontrollable coughing, produced a recurrence of stress incontinence, which we have so far been unable to correct.

The Place of Exercises and Non-Operative Therapy in the Treatment of Stress Incontinence

In reviewing our experience in this study of stress incontinence, we have gained the impression that stress incontinence may occur under almost any circumstances—in the parous and nulliparous, in women with prolapse and without any evidence of pelvic relaxation, in the young and the aged. It may persist after an otherwise successful correction of uterine and vaginal prolapse. It may appear postoperatively after the surgical correction of prolapse.

In other words, stress incontinence has been found to occur under the most diverse circumstances. Whether there is any common denominator among these factors, we have not been able to determine, unless perhaps it be a weakness of the sphincter mechanism. This has appeared to us to be the most likely common factor, inasmuch as under all these diverse conditions, exercises have in the majority of instances improved urinary control. Whether these exercises might relieve stress incontinence in any other way, we cannot tell.

In view of this experience, and also the experience of Kegel, it appears that stress incontinence may be more than a surgical problem. We have listed some of the factors that seem to have played a part in its production and our results in eliminating these factors before operative treatment is considered. In general, we believe that in any person who complains of stress incontinence and in whom there is no other indication for surgical treatment, non-operative treatment should be tried first, as we have suggested. In our experience, in three-fourths of these cases, the benefit of non-operative care will be so great that an operation will not be needed. If, however, in a patient with stress incontinence, a condition is found which might contribute to poor urinary control or in itself require surgical correction, such as uterine or vaginal prolapse, under such conditions we would perform the indicated surgical procedure and at the same time do a Kelly plication of the vesical sphincter or one of the other satisfactory procedures of this sort. If, after this surgical treatment, urinary control is still poor, we would attempt to determine its cause and institute proper treatment. In a number of such cases, exercises have been very helpful. In other words, in our experience, such non-operative measures have proved themselves a useful addition in our methods of treating stress incontinence in women.

BIBLIOGRAPHY

Berkow, S. G.: The Corpus Spongeosum of the Urethra: Its possible Role in Urinary Control and Stress Incontinence in Women. Am. J. Obst. & Gyn. **65:** 346–351 (Feb.) 1953.

Counseller, Virgil S.: Methods and Technics for Surgical Correction of Stress Incontinence. J. A. M. A. **146:** 27–31 (May 5) 1951.

Hodgkinson, C. P.: Relationships of the Female Urethra and Bladder in Urinary Stress Incontinence. Am. J. Obst. & Gyn. **65:** 560–573 (March) 1953.

Ingelman-Sundberg, Axel: Urinary Incontinence in Women, Excluding Fistulas. Acta Obstetrica et Gynecologica Scandanavica XXXI fasc. 3, 1952.

Jones, E. G., and Kegel, A. H.: Treatment of Urinary Stress Incontinence: With Results in 117 Patients Treated by Active Exercise of the Pubococcygei. Surg., Gynec. & Obst. **94:** 179–189 (Feb.) 1952.

Kegel, A. H.: Physiologic Therapy for Urinary Stress Incontinence. J. A. M. A. **146:** 915–918 (July 7) 1951.

Kegel, A. H.: Physiologic Treatment of Poor Tone and Function of the Genital Muscles and of Urinary Stress Incontinence. West J. Surg. **57:** 527–535 (Nov.) 1949.

Kegel, A. H.: Progressive Resistance Exercise in the Functional Restoration of the Perineal Muscles. Am. J. Obst. & Gynec. **56:** 238–248 (Aug.) 1948.

Kelly, A. H.: Incontinence of Urine in Women. Urol. and Cutan. Rev. **17:** 291, 1913.

Kelly, A. H. and Dumm, W. M.: Urinary Incontinence in Women, without Manifest Injury to the Bladder. Surg., Gynec. & Obst. **18:** 444, 1914.

Lennon, G. Gordon: Stress Incontinence: A Preliminary Report on a New Method of Treatment. Brit. M. J.: No. 4775, 1384, 1952.

Marchetti, A. A.: Personal communication, 1952.

Marchetti, A. A.: Urinary Incontinence. South. Med. J. **43:** 502–505 (June) 1950.

TeLinde, R. W.: Surgical Cure of Urinary Incontinence in Women. Ann. Surg. **126:** 64–97 (July) 1947.

Wharton, L. R.: The Non-Operative Treatment of Stress Incontinence in Women. J. of Urol. **69:** 511–519 (April) 1953.

* * * * *

DEPARTMENT OF EDUCATION, BALTIMORE, MARYLAND

Division of Health and Physical Education

Secondary School Physician Needed

Service—2 hours per day—5 days per week in the Secondary Public Schools of Baltimore.

Salary—$1800.00 per year, which amounts to approximately $600.00 per trimester, $200.00 per month, or $50.00 per week.

Those interested apply to: Dr. D. C. Wharton Smith, Supervisor of Health Services, Telephone—BE. 5-6300

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

Dr. A. Wolferman, Frostburg physician, is now serving a three year residency at the Eye, Ear, Nose and Throat Hospital in Baltimore. Dr. Wolferman attended medical school in Switzerland and graduated from the University of Geneva in 1940. Following graduation he served one year of internship and two years of residency in internal medicine at the University Hospital, of the City of Geneva. He was Assistant Superintendent of a Tuberculosis Hospital in Switzerland for two years and a resident physician at the Maryland Tuberculosis Sanitorium for two years. From 1948 until July, 1953, Dr. Wolferman did general practice in Frostburg, belonging to the staff of the Miners Hospital in Frostburg and the Sacred Heart Hospital, in Cumberland.

Dr. Leo H. Ley, of Cumberland has been appointed City Physician, to replace Dr. John K. Rozum who resigned two months ago shortly before moving to Florida. Dr. Ley has been practicing in Cumberland about 15 months. He is a veteran of World War II and completed medical studies at the University of Maryland following service with the armed forces. Dr. Ley served his internship and residency at St. Agnes Hospital, Baltimore, Md.

Dr. E. I. Baumgartner, of Oakland, Md. spoke at a recent meeting of the Woman's Civic Club, Oakland. The title of his subject was "The Golden Era of Therapeutics." Dr. Baumgartner is secretary of the Section on General Practice of the American Medical Association and a member of the board of directors of the American Academy of General Practice. He is also a member of the Town Council of Oakland and Deputy Medical Examiner.

The following article appeared in the Cumberland Evening Times, Aug. 9, 1953:

DR. FRANTZ EXPLAINS FEAR OF POLIO OFTEN EXCESSIVE

Don't be too worried about poliomyelitis, Dr. Winter R. Frantz, county health officer, advised today. Polio is not as common and usually not as dangerous as many other less publicized illnesses, he explained adding that rheumatic fever, tuberculosis, and many handicapping conditions, such as accidental injuries, tumors, epilepsy, cerebral palsy and a host of others are more to be feared. No cases have been reported in Allegany County this year.

During the last four polio epidemics in Maryland, in 1944, 1949, 1950 and 1952, Dr. Frantz stated the total number of reported cases showing any sign of paralysis averaged only 341 for the entire state during the epidemic year, or only one case in about 2,300 of the population under age 20. Moreover, he continued about 76 per cent of the cases diagnosed as paralytic poliomyelitis eventually recovered with little or no handicap. On the basis of these statistics, Dr. Frantz said the risk of contracting severely paralyzing polio is only about 1 in 10,000, even during an epidemic year.

Deaths and severe disabilities resulting from rheumatic fever, accidents and tuberculosis far exceed those caused by polio, Dr. Frantz pointed out.

Knowledge of the facts of polio often helps to calm fears, he said. "We know," he continued, "that transmission of the disease for the great majority of cases is by association with infected persons and that there are approximately 200 non-paralytic infections to every paralytic case. During any outbreak, therefore, the virus is so widely spread that quarantine methods other than prompt isolation of recognized cases is useless," Dr. Frantz commented.

The health officer pointed out current scientific evidence compiled at Johns Hopkins University indicates ultimate escape from infection is impossible and that temporary escape is undesirable as it postpones infection to later ages when its consequences are more severe.

Dr. Frantz also explained that people 15 years of age and older usually build up antibodies which protect them from at least one of the known polio viruses. During childhood, he said, contacts usually unknown at the time give this immunity to polio viruses. Children who have no reserve of antibodies, Dr. Frantz continued, are more susceptible than adults for this reason.

Gamma globulin, the blood derivative being used as a temporary polio preventive, will be available in Maryland only to children under 18 years and to pregnant women living in the same individual household with a proven polio victim, except in the case of a recognized epidemic, Dr. Frantz said. If advisable, he added, mass inoculations will be given in the high-risk age groups where there is an epidemic.

Gamma globulin, which induces immunity for approximately five weeks, is at best temporary preventive, Dr. Frantz pointed out, explaining that there is no cure for polio once the nerve cells have been affected. The prospects are bright for active immunity, he said, in view of recent scientific progress.

"Above all don't become hysterical about polio," he cautioned.

Baltimore City Medical Society and its Sections

Meetings will be held at 1211 Cathedral Street unless otherwise stated

BALTIMORE CITY MEDICAL SOCIETY

Friday, November 20, 1953, 8:30 p.m.

CO-SPONSORSHIP WITH THE HEART ASSOCIATION OF MARYLAND

8:45 p.m.

The Medical Management of Acute and Chronic Anterior Occlusion. A. Wilbur Duryee, M.D., Professor of Clinical Medicine, Postgraduate Medical School of the New York University-Bellevue Medical Center, New York City.

9:30 p.m.

The Physical Aspects of Peripheral Vascular Disease. Jere W. Lord, Jr., M.D., Associate Professor of Clinical Surgery, Postgraduate Medical School of the New York University-Bellevue Medical Center, New York City.

10:15 p.m.

Question period.

SECTION ON DISEASES OF THE CHEST

A. Murray Fisher, M.D., *Chairman* — Edmund G. Beacham, M.D., *Secretary*

Wednesday, November 4, 1953, 8:00 p.m.

Emotional Aspects of Pulmonary Tuberculosis. Jerome Hartz, M.D., Assistant Professor of Psychiatry, The Johns Hopkins University School of Medicine.

OTOLARYNGOLOGICAL SECTION

C. Carleton Douglass, M.D., *Chairman* — Albert Steiner, M.D., *Secretary*

Tuesday, November 10, 1953

Johns Hopkins Club, Homewood Campus

Cocktails 6:00 p.m. *Dinner 6:30 p.m.*

Papers will be presented by the Residents of the various hospitals.

MATERNAL MORTALITY COMMITTEE

Thursday, November 19, 1953, 4:00 p.m., Osler Hall

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and the Baltimore City Health Department.

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty.

Richard W. TeLinde, M.D., *Chairman* Beverley C. Compton, M.D., *Secretary*

Thursday, November 19, 1953, 5:00 to 6:00 p.m.

DERMATOLOGICAL SECTION

Eugene S. Bereston, M.D., *Chairman* Raymond C. V. Robinson, M.D., *Secretary*

Monday, November 23, 1953, 8:30 p.m.

1. Election of Officers.
2. Experimental Contact Dermatitis with Dinitrochlorobenzene. (Illustrated.)
   Israel Zeligman, M.D.

DORCHESTER COUNTY MEDICAL SOCIETY

WALTER B. JOHNSON, M.D.

Journal Representative

The Dorchester County Medical Society usually meets the third Wednesday of each month, but discontinues meeting for June, July, and August.

On July 22nd, however, Dr. John Mace, Jr., of Cambridge, entertained the society at his summer home at Greenpoint on the Choptank River, to a crab feast. There was no business meeting, but a very enjoyable social evening was held.

Dr. George Currier, who was appointed Superintendent of the Eastern Shore State Hospital, and who formerly was a member of the Massachusetts State Medical Society has applied for membership in the local county and state associations.

Dr. Thomas Dredge, Clinical Director at the Eastern Shore State Hospital, also presented a card of transfer from the Green Bay, Wisconsin Medical Society.

Dr. Wilbur Baumann who was recently released from the United States Navy has applied for membership in the county and state societies.

* * * * *

REQUESTING THAT ALL DEATHS ASSOCIATED WITH PREGNANCY BE REPORTED!

John Whitridge, Jr., M.D.*

The Committee on Maternal and Child Welfare of the Medical and Chirurgical Faculty has for many years been reviewing all maternal deaths among residents of the counties of Maryland. Recent changes in statistical classification of deaths have raised certain difficulties in regard to whether a death should be officially classified as maternal or non-maternal. The Committee is anxious to review *all* adult deaths associated with pregnancy. Such deaths, whether classified as maternal, or non-maternal, would be tabulated annually as "Total Deaths Associated with Pregnancy."

In order to make this comprehensive review possible, all physicians are accordingly urged to indicate in an appropriate place on death certificates the fact that patients were or had recently been pregnant, even though, in the reporting physician's opinion, pregnancy or delivery may have played no role whatever in causing death.

* Secretary, Committee on Maternal and Child Welfare, Medical and Chirurgical Faculty.

NEW MOUNT PLEASANT HOSPITAL NOW OPERATING IN BALTIMORE*

Baltimore's new Mount Pleasant Sanitorium, a fifty-four bed hospital, located at Greenspring and Belvedere Avenues, is an example of a completely self-contained specialized tuberculosis hospital integrated into a modern medical center. The national magazine, "Modern Hospital," has characterized Mount Pleasant as an outstanding example of a modern up-to-date hospital for tuberculosis and other pulmonary diseases.

Mount Pleasant is the third completed unit of the $16,000,000 Jewish Medical Center expansion program of the Associated Jewish Charities. Also, already completed are two new buildings at Levindale, a home for the aged, a new dining hall and a new fifty bed infirmary addition, as well as the Mount Pleasant Building. The entire Jewish Medical Center is being built on grounds adjacent to Levindale. Final plans for the new Sinai, now located at East Monument Street, are expected to be ready by the Fall of 1954, at which time it is expected that ground will be broken for Sinai's first six buildings.

The new Jewish Medical Center, comprising 150 acres that includes four corners at Belvedere and Greenspring Avenues, will give Baltimore its third major medical center. It will have a total capacity in the three autonomous hospitals of 745 beds, 231 at Levindale, 54 at Mount Pleasant and 460 at Sinai.

Built at a cost of $1,400,000, the fifty-four bed Mount Pleasant is divided into eighteen double rooms and sixteen single rooms, almost all of which open on to porches and terraces, and all of which have private toilet facilities. The hospital also contains its own dining-room, kitchen, auditorium, Synagogue, library, radiology department, oxygen room, motion picture projection room and occupational therapy facilities.

Mount Pleasant, which was founded by the late Jacob Epstein in 1908, was formerly located on a 135-acre tract of land in Reisterstown, Md., twenty miles outside of Baltimore. The property, which is now being offered for sale or rent by the Associated Jewish Charities, includes a hospital building, dining hall, nurses' dormitory and several brick cottages as well as farm buildings.

---

* Henry W. Levy, Publicity Director, Associated Jewish Charities.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

EPILEPSY

LOUIS KRAUSE, M.D.*

This month's publication of books will be devoted to the treatises on Epilepsy. This is a very ancient disease, having been called the "sacred disease" by the ancients; sacra medica by the Romans or Morbis Comitialis. In English, this is called comitial or congress disease. This is another instance of disease, the description of which we have very graphically presented in our Bibles, particularly in the New Testament. In Mark, 9th chapter, 17th verse, we have the following quotation, "... Master, I have brought unto thee my son, which hath a dumb spirit;

Verse 18 "And wheresoever he taketh him, he teareth him: and he foameth, and gnasheth with his teeth, and pineth away....

Verse 20 "... and when he saw him, straightway the spirit tare him; and he fell on the ground, and wallowed foaming."

Verse 21 "And he asked his father, How long is it ago since this came unto him? And he said, Of a child."

Verse 22 "And ofttimes it hath cast him into the fire, and into the waters, to destroy him....

Verse 25 "... Thou dumb and deaf spirit, I charge thee, come out of him, and enter no more into him.

Verse 26 "And the spirit cried, and rent him sore, and came out of him.

Again another reference of the same incident is in the Book of Luke, Chapter 9, Verse 39 "And, lo, a spirit taketh him, and he suddenly crieth out; and it teareth him that he foameth again, and bruising him hardly departeth from him."

These passages describe the essential manifestations of the disease as we know it even today, the only thing lacking being the electroencephalogram.

An amazing description of the sacred disease was given by Hippocrates which really was the highest reach of free thought for centuries; and had his statements been heeded, it would have done away with the foolish notion that human ills were caused by gods and demons and certainly with the notion that epilepsy was of divine origin.

The disease has often been referred to the phases of the moon and some mental diseases were classified as diseases related to the changes of the moon. Hence the word *lunatic*. Likewise, this is one of the reasons why silver nitrate was used at one time in the treatment of epilepsy because of silver being the moon metal and it was thought to be efficacious in such diseases.

The present term, *Epilepsy*, comes from the Greek meaning *seizure upon*. The following list of books which are available in our Library will afford much interesting study and reading on this disease, which is more effectively treated today than ever before:

Althaus, J. On epilepsy, hysteria and ataxy. London, John Churchill & Sons, 1866.
Association for Research in Nervous and Mental Disease. Epilepsy. Baltimore, Williams & Wilkins Co., 1947.
same. Epilepsy and the convulsive state. Baltimore, Williams & Wilkins Co., 1931.
The Committee of Fifty. How the uncared-for epileptic fares in Illinois, n.p., 1913.
Corning, J. L. A treatise on hysteria and epilepsy. Detroit, Davis, 1888.
Crawfurd, R. H. P. The blessing of cramp-rings; a chapter in the history of the treatment of epilepsy. *in* Singer, C. Studies in the history and method of science. volume 1 Oxford, Clarendon Press, 1917.
Echeverria, M. G. On epilepsy; anatomo-pathological and clinical notes. New York, W. Wood & Co., 1870.
Godwin, J. Disputatio medica inauguralis de epilepsia. Edinburgh, Balfour, Auld, et Smellie, 1769.
Gowers, W. R. The borderland of epilepsy. Philadelphia, P. Blakiston's Sons & Co., 1907.
same. Epilepsy and other chronic convulsive diseases. 1st ed., New York, W. Wood & Co., 1885. 2d ed., Philadelphia, P. Blakiston's Sons & Co., 1901.
Hall, M. On the threatenings of apoplexy and paralysis, inorganic epilepsy, etc. London, Longman, Brown, Green & Longman, 1851.
Hare, H. A. Epilepsy; its pathology and treatment. Philadelphia and London, F. A. Davis, 1890.
Hendriksen, V. Spasmophilie og epilepsie samt bidrag til det epileptiske anfalds pathogenese. Køb., Levin, 1928.

---

* Chairman, Library Committee.

Kussmaul, A. On the nature and origin of epileptiform convulsions caused by profuse bleeding, and also of those of true epilepsy. London, New Sydenham Society, 1859.

Lennox, W. G., and Cobb, S. Epilepsy. Baltimore, Williams & Wilkins Co., 1928.

same. Science and seizures; new light on epilepsy and migraine. New York and London, Harper & Brothers, 1941.

Letchworth, W. P. Care and treatment of epileptics. New York and London, G. P. Putnam's Sons, 1900.

Lundborg, H. Die progressive Myoklonus-epilepsie. Upsala, Almqvist & Wiksell, 1903.

Mansford, J. G. The nature and causes of epilepsy. Bath, Longman, Hurst, Reese and Orme, 1819. (Monographs, vol. 16)

Muskens, L. J. J. Epilepsy; comparative pathogenesis, symptoms, treatment. New York, W. Wood & Co., 1928.

New York State Board of Charities. Bureau of Analysis and Investigation. Nine family histories of epileptics in one rural county. Albany, The Bureau, 1916.

Ninde, F. W. The application of the auditory memory span test to two thousand institutional epileptics. West Chester, Temple Press, n.d. (1927?).

Putnam, T. J. Convulsive seizures, how to deal with them. Philadelphia, London, J. B. Lippincott Co., 1943.

Radcliffe, C. B. Epilepsy and other affections of the nervous system. London, J. Churchill, 1854.

Recherches clinques et thérapeutiques sur l'épilepsie, l'hystérie et l'idiotie. Paris, Progrès Médical, 1881–1902. In 20 vols. Library has v. 13, 1892 and v. 14, 1893.

Rows, R. G., and Bond, W. E. Epilepsy; a functional mental illness. New York, P. B. Hoeber, 1926.

Schroeder van der Kolk, J. L. K. On the minute structure and functions of the spinal cord and medulla oblongata and on the proximate cause and rational treatment of epilepsy. London, The New Sydenham Society, 1859.

Spratling, W. P. Epilepsy and its treatment. Philadelphia, W. B. Saunders & Co., 1904.

Talbot, F. B. Treatment of epilepsy. New York, Macmillan, 1930.

Temkin, O. The falling sickness; a history of epilepsy from the Greeks to the beginning of modern neurology. Baltimore, Johns Hopkins Press, 1945.

Terry, G. C. Fever and psychoses. New York, P. B. Hoeber, 1939.

Tissot, S. A. A. D. Traité de l'épilepsie, faisant le tome troisième de traite des nerfs et de leurs maladies. Paris, P. F. Didot, 1770.

Turner, W. A. Epilepsy; a study of the idiopathic disease. London, Macmillan & Co., Ltd., 1907.

Turpin, P. Dissertatio medica inauguralis de epilepsia. Edinburgh, Balfour & Smellie, 1774.

Vance, R. A. On syphilitic epilepsy. New York, Christern, 1871.

Voisin, A. F. De l'épilepsie simulée et son diagnostic par des caractères spyhgmographiques du pouls. Paris, J. B. Baillière et fils, 1868.

same. Recherches cliniques sur le bromure de potassium et sur son emploi dans le traitement de l'épilepsie. Paris, Au Bureau du journal, 1866.

same. L'épilepsie. Paris, G. Baillère, 1879.

Weber, L. W. Beiträge zur pathogenese und pathologischen anatomie der epilepsie. Jena, G. Fischer, 1901.

White, S. Disputatio medica inauguralis de epilepsia. Edinburgh, Adamus Neill et Socii, 1798.

Woods, M. In spite of epilepsy; being a review of the lives of three great epileptics, Julius Caesar, Mohammed, Lord Byron. New York, The Cosmopolitan Press, 1913.

LIBRARY NOTES

We report with regret the resignation, effective September 30th, of Mrs. Eleanor Kohler, who has been a most valuable assistant in the Library since May 1949. Her quick and intelligent help, her enthusiasm, and her cheerful disposition will be missed by everyone, and she carries with her all good wishes for her happiness in the family life she has chosen for her career.

We welcome her successor, Miss Myrtle Hollins, and wish her happiness and success in her work in the Library.

A SELECTED LIST OF PUBLICATIONS RECENTLY ADDED TO THE LIBRARY

Armstrong, J. R. Lumbar disc lesions: pathogenesis and treatment of low back pain and sciatica. Baltimore, Williams and Wilkins Co., 1952.

*Baer, K. A. Pathology and physiology of burns: an annotated bibliography, 1942–1951. Washington, Armed Forces Medical Library, 1952.

Baldwin, E. Dynamic aspects of biochemistry. 2d ed. Cambridge, University Press, 1952.

Brock, S. Basis of clinical neurology. 3d ed. Baltimore, Williams and Wilkins Co., 1953.

*Browning, E. Toxicity of industrial organic solvents. London, H. M. Stationery Office, 1953.

Cantor, A. J. Ambulatory proctology. 2d ed. New York, Hoeber, 1952.

Cattell, R. B. and Warren, K. Surgery of the pancreas. Philadelphia, W. B. Saunders, 1953.

*Cavina, C. Indicazioni ed i metodi della resezione epatica. Bologna, Cappelli, 1952.

Clark, G. W. Vitamin digest. Springfield, C. C Thomas, 1953.

Coope, R. The quiet art, a doctor's anthology. Edinburgh and London, Livingstone (Baltimore, Williams & Wilkins), 1952.

* Indicates gifts.

Courville, C. B. Commotio cerebri. Los Angeles, San Lucas Press, 1953.

Dale, P. M. Medical biographies: the ailments of 33 famous persons. Norman, University of Oklahoma Press, 1952.

Decker, A. Culdoscopy, a new technique in gynecologic and obstetric diagnosis. Philadelphia, W. B. Saunders, 1952.

Gross, R. E. Surgery of infancy and childhood. Philadelphia, W. B. Saunders, 1953.

Johnson, J. and Kirby, C. K. Surgery of the chest. Chicago, Year Book Publishers, 1952.

Jukes, T. H. B-vitamins for blood formation. Springfield, C. C Thomas, 1952.

Lewin, P. The knee and related structures. Philadelphia, Lea and Febiger, 1952.

Maingot, R. Management of abdominal operations. New York, Macmillan Co., 1953.

*Merck and Company. Annotated bibliography on cortone. Rahway, Merck and Co., 1953.

*Moloney, J. C. The battle for mental health. New York, Philosophical Library, 1952.

Monro, T. K. The physician as man of letters, science and action. 2d ed. Baltimore, Williams and Wilkins Co., 1951.

Najjar, V. A. Carbohydrate metabolism. Baltimore, Johns Hopkins Press, 1952.

Selye, H. Physiology and pathology of exposure to stress. Montreal, Acta, Inc., 1950.

Sharpe, W. Brain surgeon: the autobiography of Dr. William Sharpe. New York, Viking Press, 1952.

Simpson, K. Modern trends in forensic medicine. St. Louis, C. V. Mosby, 1953.

Slocum, D. B. Atlas of amputations. St. Louis, C. V. Mosby, 1949.

Thomas, L. Rheumatic fever. Minneapolis, University of Minnesota Press, 1952.

Thorek, P. Anatomy in surgery. Philadelphia, J. B. Lippincott, 1951.

Todd, J. C., Sanford, A. H. and Wells, B. B. Clinical diagnosis by laboratory methods. Philadelphia, W. B. Saunders, 1953.

Welch, C. E. Surgery of the stomach and duodenum. Chicago, Year Book Publishers, 1951.

Williams, H. L. Menière's disease. Springfield, C. C Thomas, 1953.

Windle, W. F. Asphyxia neonatorum. Springfield, C. C Thomas, 1950.

Wolf, S. and Wolff, H. G. Headaches, their nature and treatment. New York, Little, Brown and Co., 1953.

Zeigler, R. F. Electrocardiographic studies in normal infants and children. Springfield, C. C Thomas, 1951.

* Indicates gifts.

STUDY OF VA MEDICAL CARE MAY GO OVER TO NEXT SESSION

AMA Washington Letter, No. 28

The House Veterans Affairs subcommittee study of the knotty problem of VA medical care for non-service-connected cases may take much longer than originally anticipated. First indication of this came on the opening day of hearings when Chairman Pat Kearney (R.-N.Y.) commented that he wanted all veterans' groups to make concrete recommendations on the issue "after their conventions this fall." Rep. Kearney cautioned that unless the committee came up with some specific legislation, Congress itself "might jam something through that we will all be sorry for." Among questions the committee is seeking answers to are: What is the definition of service-connected disability? How far should Congress go beyond the present GI Bill of Rights in saying what the government owes in non-service-connected cases? Would enforcement of the existing inability-to-pay provisions for non-service cases be preferable to new legislation?

Testimony of veterans' groups up to this point indicated that there is no unanimity of opinion on the problem. The Veterans of Foreign Wars promised some stand would be taken at the annual encampment in August; the Disabled American Veterans felt that better policing of existing regulations is preferable to new legislation; the AMVETs advocated clear-cut language in a law to wipe out abuses.

STATE OF MARYLAND DEPARTMENT OF HEALTH

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, August 28–September 24, 1953

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS
																			Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County	2	—	—	17	—	1	9	18	18	—	1	—	—	5	29	1	12	a-1	7
Anne Arundel	2	—	—	1	—	—	1	6	3	—	—	—	—	—	9	—	4	—	1
Howard	—	—	—	—	—	—	—	4	1	—	—	—	—	—	2	—	4	—	—
Harford	1	—	1	2	2	—	2	4	1	1	—	1	—	8	2	—	1	—	1
Carroll	—	—	—	2	2	—	1	1	—	1	—	—	—	—	—	—	—	—	6
Frederick	—	—	2	1	—	—	—	3	3	—	2	—	—	3	—	—	—	—	—
Washington	1	—	—	—	2	—	—	—	—	—	—	—	—	1	7	—	2	—	—
Allegany	—	—	—	3	4	—	1	—	—	2	—	2	—	5	1	—	—	—	1
Garrett	—	—	—	2	—	—	—	—	2	—	—	—	—	—	1	—	—	—	—
Montgomery	—	—	2	—	—	—	2	6	6	1	1	—	—	—	9	—	—	—	2
Prince George's	—	—	1	5	—	—	4	5	5	—	—	—	—	2	6	—	3	m-1	3
Calvert	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—
Charles	—	—	—	—	—	—	—	1	2	—	—	—	—	—	2	—	2	—	—
Saint Mary's	—	—	—	16	—	—	—	—	1	—	—	—	—	—	—	—	2	—	—
Cecil	—	—	—	—	—	—	—	1	—	—	—	—	—	—	3	—	1	m-1	1
Kent	2	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Queen Anne's	—	1	—	—	—	—	—	1	2	—	—	—	—	—	—	—	—	—	—
Caroline	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1	—	—
Talbot	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	1	—	1
Dorchester	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	12	—	—
Wicomico	—	—	—	1	3	—	—	—	—	—	2	—	—	1	1	—	25	—	2
Worcester	—	—	—	—	—	—	—	—	2	—	—	—	—	2	—	2	1	c-1	—
Somerset	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	5	—	—
Total Counties	8	1	6	51	13	1	20	50	47	5	6	3	0	28	74	4	77		25
Baltimore City	7	0	5	4	17	1	34	29	25	0	6	0	0	49	102	8	668	—	18
State																			
Aug. 28–Sept. 24, '53	15	1	11	55	30	2	54	79	72	5	12	3	0	77	176	12	745		43
Same period 1952	7	0	8	17	10	5	37	49	34	3	17	0	0	9	194	25	680		23
5-year median	15	2	5	—	29	1	23	55		7	20	4	2	78	197	53	705		28
Cumulative totals																			
State																			
Year 1953 to date	2698	10	1426	384	1488	60	2235	218	175	23	2181	22	9	300	1772	106	5864		567
Same period 1952	2736	7	831	174	9068	71	910	92	70	28	836	15	12	160	2020	146	5374		498
5-year median	3039	57	525	—	3983	59	1586	145		53	878	25	33	607	2066	652	5515		470

a = amoebic dysentery.
c = congenital syphilis under 1 year of age.
m = malaria contracted outside of Maryland.

Blue Cross - Blue Shield

BLUE CROSS AND BLUE SHIELD CONTINUE TO GROW

R. H. DABNEY*

During the first six months of 1953, Blue Cross payments for hospital care totalled $5,821,103, an all-time high for the fifteen years the Plan has been in operation.

These payments were made for hospital services provided to 60,193 subscribers of the Plan. During the same period a year ago, 56,426 subscribers received care for which Blue Cross paid $5,157,891. Hospital costs have gone up and more people are going to the hospital.

The average length of stay for patients was 7.3 days, and payments on individual cases ranged from $25 to over $2,000 for long-stay serious illnesses.

During the first half of the year, payments for hospital care amounted to 92.7 cents out of every dollar received, and only 6.4 cents out of each dollar was used for operating expenses. Membership in Maryland's Blue Cross Plan as of June 30 was 869,000, an all-time high and an increase of 10,000 subscribers since the first of the year. Nationally, there are now over 44 million subscribers.

Meanwhile, membership in Blue Shield continued to grow. There are now 200,000 subscribers, an increase of 12,000 since January 1.

Publication of these figures made the position of voluntary health plans in the national health picture subject of an editorial in the August 5 Baltimore Sun. "A popular argument for national compulsory health insurance has been that no voluntary plan can be made to cover a sufficiently large proportion of the population. In conflict with this theory is the recent phenomenal growth of volunteer plans and, in particular, Blue Cross and Blue Shield," the editorial begins.

The editorial points out that at present nearly 36 per cent of Maryland's population is covered by Blue Cross compared to national membership of 27.34 per cent of the population. In Rhode Island Blue Cross membership takes in 78 per cent of the state's population. Membership continues to grow, in spite of the fact that enrollment must be by groups and, in consequence, there are many individuals who are ineligible. All this would seem to refute the argument that no voluntary plan can be made to cover a sufficiently large proportion of the population.

The editorial concludes, "Blue Cross and Blue Shield are, of course, only a part of the prepayment picture. According to the report of the Truman Health Commission, commercial insurance company payments directly related to medical care expenses and specifically paid for the purpose of defraying those expenses amounted in the single year of 1951 to $768,000,000. When the American public shows so impressive an inclination to insure itself against the costs of medical care, surely it is premature to press for compulsory insurance as the only solution of the problem."

---

* Executive Director, Maryland Hospital Service, Inc., Maryland Medical Service, Inc.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. CHARLES H. WILLIAMS, *Auxiliary Editor*

PRESIDENT'S MESSAGE

MRS. JOHN G. BALL

I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals.

This is the pledge we say at Auxiliary meetings and which is always most impressive at the national conventions. There, we hear voices from every state in the union, Hawaii and Alaska pledging themselves to the work of the Auxiliary.

Now, just what is that work? Those high ideals? Our Constitution states our objects to be: (1) Through our members to extend the aims of the medical profession to all organizations which look to the advancement of health and health education; (2) To fulfill such functions as may be desired from time to time by the Medical and Chirurgical Faculty of the State of Maryland; (3) To promote acquaintanceship among physicians' families that fellowship may increase and at all times to stimulate a feeling of local cooperation. Each of these objects is important and vital to the medical profession in Maryland. No one member or one county can do this alone. Accomplishment of our objects depends on the willingness of each individual member to do her part.

At the National Convention in New York, June 1–5, 1953, we were shocked to learn that Maryland is at the very bottom of the list for Woman's Auxiliary Membership Percentage of the American Medical Association membership, that percentage being 23.5%. Now is the time for us, each and every one of us, to get busy and find those friends of ours in unorganized counties, visit them, talk with them about the Auxiliary, tell them our objects, the work we have been doing, and how rewarding the contacts and friendships we make, become. Your Organization Chairman, Mrs. Albert Goldstein, and your President will be happy to visit or have any suggestions you may have. The most successful membership and organization work has just one secret—"personal contact and interest." At the Presidents' Conference following the New York meeting, Mrs. Leo J. Schaefer, our National President, gave us this theme: "Together we progress." Let us work together for progress in membership and organization.

As we strive for more members and more organized counties, let us not forget the work we have already started that needs our continuing support. In New York, we were proud to report our successful Future Nurses Convention held in Baltimore on May 12, 1953, when nearly 400 enthusiastic high school girls heard speakers on all phases of nursing, saw American Medical Association nursing films, and heard student nurses, in uniform, from 14 hospitals speak. All our organized counties have nursing scholarships. A Nurse Recruitment film is being made of the nursing schools in Maryland and will be ready for use this winter. Some of the high schools have Future Nurse Clubs which interest and teach the girls about nursing. More county Auxiliaries should sponsor these groups. In these ways we are meeting the challenge of the shortage of nurses which the American Medical Association has requested of us.

There are other continuing challenges for us; one of the greatest is in the field of Public Relations or "Public Responsibility" as one state has so aptly paraphrased it. Each doctor's wife needs to be informed and keep informed so she may be prepared to talk with the lay persons she meets daily, when questions are asked. Have you noticed that you can scarcely pick up a magazine but what there is some challenging article related to medicine, physicians, medical fees, malpractice suits, doctor shortage, emergency service and a host of other questions vital to us as physicians' wives and Auxiliary members. As individuals, we participate in many activities of educational, civic and religious organizations. All of these contacts are most important and should be extended. Public service is the ultimate goal of public relations. How best may we serve our communities in the field of health? The American Medical Association has been increasing its public service by developing voluntary health insurance, doctor placement service, emergency call systems, exposing quacks and continuing to look for a solution to the problem of the chronically ill, aging, and mentally ill. Above all, we must continue to maintain the prestige and esteem of the medical profession in the eyes of the public.

Civil Defense needs our continuing greater interest and effort. Much of the organizational work has been completed so we should be able to see definite progress this year. Each one should find the place she may best help in her local organization.

Last year the American Medical Association asked the Auxiliary to help the American Medical Education Foundation with the problem of raising money for the medical schools of the Country, most of which have large deficits. The National Auxiliary gave $10,000 to the Foundation at the New York meeting. Efforts must be continued to meet the goal of $2,000,000 for this year. Let us continue to urge all physicians to subscribe to their medical schools through the American Medical Education Foundation. All such money given by physicians through the Foundation is matched by funds subscribed by private industry. Speak to your husband about this.

To help us in all these important tasks, we have the "Bulletin of the Woman's Auxiliary to the American Medical Association." Each National Chairman through her contacts throughout the States and through the States to the Counties has a wealth of information and help to offer each of us. The only way we can avail ourselves of this help is to subscribe to the "Bulletin." Until we all start reading and using the material presented to us, we are not beginning to do our job. If you do not subscribe, please do. The Bulletin Chairman, Mrs. S. Jack Sugar, 6709 41st Avenue, University Park, Maryland, will be happy to take your subscription for $1.00.

Another object of the Auxiliary was fulfilled with the Semiannual Meeting. The Auxiliary helps with the planning and entertainment of all such meetings, as requested by the Medical and Chirurgical Faculty.

PRESIDENTIAL APPOINTMENTS

Mrs. John G. Ball, President, has appointed the following Chairmen:

Standing Committees: "Today's Health," Mrs. S. R. Wells, Hagerstown; Legislation, Mrs. H. Hanford Hopkins, Ruxton; Organization, Mrs. Albert E. Goldstein, Baltimore; Public Relations, Mrs. George H. Yeager, Baltimore; Program, Mrs. T. A. Christensen, College Park; Finance, Mrs. Elliott C. Flick, Towson; Historian, Mrs. P. S. Lansdale, Frederick; Revisions and Resolutions, Mrs. Amos R. Koontz, Garrison; Doctor's Day, Mrs. Gerald Le Van, Boonsboro; Press and Publicity, Mrs. Charles H. Williams, Pikesville; Bulletin, Mrs. S. Jack Sugar, University Park; Members-at-Large, Mrs. James T. Marsh, Westminster.

Special Committees: Civil Defense, Mrs. Arthur Baptisti, Jr., Hagerstown; Nurse Recruitment, Mrs. James Kerr, Damascus; Medical Education Foundation, Mrs. J. Carlton Wich, Baltimore; Membership, Mrs. Martin Strobel, Reisterstown; Convention Arrangements, Mrs. George E. Urban, Catonsville; Auxiliary Editor (Maryland State Medical Journal) Mrs. Charles H. Williams, Pikesville.

BALTIMORE COUNTY AUXILIARY AWARDS THIRD NURSING SCHOLARSHIP

The Woman's Auxiliary to the Baltimore County Medical Society awarded their third Nurse's Scholarship to Miss Mary Hughes of Catonsville. Dr. A. B. Daugharthy (the family physician of Miss Hughes) presented the award which will enable this student to attend the Johns Hopkins School of Nursing in September.

MARYLAND AUXILIARY GIVEN NATIONAL RECOGNITION

MARYLAND AUXILIARY PLANNING NURSE RECRUITMENT FILM

Reprinted from A.M.A. Woman's Auxiliary Bulletin Dec. 1952

As a public relations project, the Maryland Auxiliary, in cooperation with the local hospitals schools of nursing, state medical association and the nursing association, is making its own nurse recruitment movie. The idea originated in the Auxiliary and has been enthusiastically received. Financing and script writing are now in the hands of committees composed of members of the Auxiliary, the medical association, representatives from hospitals and nursing associations, and civic organizations. In the tentative plan presented to the cooperating groups, the Auxiliary stressed the point that the film would portray nursing *not as a selfish interest but as a service profession emphasizing ethics as is done in the practice of medicine.* The Auxiliary is looking forward to a friendly association with the hospital and nursing associations working together for the best interests of the community.

STUDENTS ADMITTED TO ALL STATE-APPROVED SCHOOLS OF NURSING DURING 1950, 1951 AND 1952

Maryland—1950, 729; 1951, 828; 1952, 765.

AMERICAN COLLEGE OF SURGEONS

The Board of Regents of the American College of Surgeons has established the first of several contemplated scholarships in the field of research for promising young men seeking a career in academic surgery, and who have recently finished or who are in the final months of their residency training program.

Because surgeons have indicated their growing interest in research, and because of the vital importance of surgical research, it is hoped that this program will encourage and stimulate the interest of young surgeons with investigative ability and promise, and direct their development toward the pursuit of academic surgery.

Although the College is able to support only one scholarship at the present time, it is believed that through the efforts of Fellows and various organizations interested in this project support of additional research scholarships will be assumed.

Candidates must obtain the approval of the chairman of the department of surgery, dean of the same medical school, and the authority of an executive officer of the university making the proposal. Preference will be given to an American or Canadian citizen.

Successful candidates will receive $20,000 over a three-year period, to be divided as follows: $6,000 for the first year, $6,500 for the second year, and $7,500 for the third year. The medical school or institution sponsoring a successful candidate may supplement this amount with the permission of the Committee on Selection of the American College of Surgeons.

Medical schools or institutions supporting the nomination of a candidate will be required to provide a satisfactory place to work, with adequate facilities, as well as funds with which to support necessary research. It is expected that the major portion of the candidate's time will be spent in clinical or experimental research.

The candidate and the institution supporting his nomination are asked to supply the College with a planned program for the nominee. On completion of the research scholarship, the medical school or institution supporting the candidacy of the nominee is expected to absorb the research scholar into its faculty and support him on a full-time basis with its own budget.

A Committee on Selection has been appointed to pass on individual candidates, their program and the conditions of work as outlined by the sponsoring institution. Final arbiter in the selection of candidates will be the Regents of the American College of Surgeons.

Inquiries may be addressed to the Research Scholarship Committee, American College of Surgeons, 40 East Erie Street, Chicago 11, Illinois.

Maryland
STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 2 *November, 1953* NUMBER 11

SYMPOSIUM ON THE MEDICAL, LEGAL AND SOCIAL ASPECTS OF THE ADOPTION LAW OF THE STATE OF MARYLAND UNDER CHAPTER 63 OF THE ACTS OF 1950[1]

INTRODUCTION

HONORABLE HERMAN MOSER, *Moderator*[2]

Ladies and gentlemen, we are here this evening, as I understand it, for the purpose of hearing a discussion and an explanation of one of the new and apparently little-understood Acts that affect the medical profession, the legal profession, those who are concerned with social service work here in the community, and, of course, the general public.

It is an Act that came into being in 1950. And it changed fundamentally and to a very great degree the adoption laws of the State of Maryland.

I have heard it said that it was passed with too little knowledge of the full implication of the law. On the other hand, I have heard it said that this subject has been debated for many, many years, and the evils which were thought to be corrected by the law were well understood by those who would be affected by its passage.

In any event, after we leave here this evening, I hope there will have been accomplished several things:

One. A better understanding of the law and its implications, and

Two. A better understanding of those evils which the law was thought to correct.

Perhaps it may lead to not only a better understanding of the law as it is, and if need be, a better law, but in any event I am sure after this group of experts in their fields are through discussing it, and then I hope with each other, we all will at least know more about it.

The first speaker is Dr. Georgeanna Seegar Jones. Dr. Jones received her degree from Johns Hopkins Medical School some years ago.

She is in the Department of Surgery at the Johns Hopkins, and has been in the Department of Gynecology as the Director of Research in Reproductive Physiology in the Department of Gynecology. Her present title at Johns Hopkins is Assistant Professor of Gynecology.

In addition to her academic position, she is a part-time private practitioner, who is largely devoted to the study of infertility.

I am perfectly sure she is going to have some interesting thoughts about the relationship between the subject with which she is thoroughly familiar and the subject which started out as an adoption law of the State of Maryland.

The next discussant is Thomas J. S. Waxter.

He is a graduate from Princeton. He is a graduate from Yale Law School. He was Chief Magistrate of the Juvenile Court of Baltimore from 1929 to 1936. He has been Director of the Department of Public Welfare since January of 1935, and, of course, that is the position that most of us are most familiar with. He helped to organize and was a member of the Board of the Baltimore Emergency Relief Association.

---

[1] Arranged by the Joint Committee on Medicolegal Problems of the Baltimore and Maryland Bar Associations and the Medical and Chirurgical Faculty, under the auspices of the Symposia Management Subcommittee.

[2] Judge of the Supreme Bench of Baltimore City.

He was a member of the group which organized the Legal Aid Bureau, and was Chairman of this Board for a great number of years.

He is President of the Maryland State Conference of Social Welfare.

He is a member of the Board of the Family and Children's Society.

He is a member of the City Jail Board and Committee for the Construction of a new Jail, which I think has become at least a drawing board reality.

He is a member of the Board of Directors of the Council of Social Agencies, and he is a member of the Board of Citizens Planning and Housing Association, as well as being a member of the Baltimore Youth Commission.

He was Chairman of the Sub-Committee on Medical Care—American Public Welfare Association.

He is Secretary of the Baltimore City Commission on Human Relations, and Administrator of Area Projects in Baltimore.

He is Director of the Emergency Welfare Services—in Civil Defense.

He also was one of the successful growers of nasturtia and radishes in Public School No. 61. (Laughter) And I can vouch for that, because we were in it together. (Laughter)

And then there is Andy Anderson—G. C. A. Anderson—who is a member of the Baltimore Bar. I almost did not know who he was until about ten minutes ago, when Mr. Waters brought me his history. I would have been at a complete loss if that had not been furnished. (Laughter)

He graduated from Mercersburg, spent one year at Princeton, and then went into the army.

He graduated from Princeton in 1921, and graduated from the Harvard Law School in 1924.

He was Secretary of the Baltimore City Bar Association, and later was President of the Baltimore City Bar Association, and was Vice President of the Maryland State Bar Association.

He was in charge of fuel oil rationing during World War II.

Incidentally, he has many other qualifications, and both as a member of the Bar and as a member of the Bench, I have known Mr. Anderson as being one who is always ever ready and willing to lend his considerable talents to any worthwhile cause. He has been used for good purposes many, many times by the Bench and the Bar in matters which the Bench and the Bar felt he could lead in order to bring about better situations.

I am perfectly sure that we all are going to leave, after hearing these three extremely well-qualified experts discuss these problems, much better informed. I know I shall.

We are going to do it in this way. I was given the rules by the Committee that is in charge of this meeting. The discussants have fifteen minutes each to develop their particular viewpoint on this question. There will then be certain questions, more or less pointed, asked by the Moderator. There are, I see, pads distributed here in the hall, and I assume there are pencils or pens available. There will be an open period of questions, but I am suggesting that before that period the questions be written down, and during the time that the Moderator is asking certain questions, those who have questions to ask will have an opportunity to pass them up, so that then we will have time to go over them, and they will be asked of the person whom the Moderator believes is best qualified to give the answers to them.

Now, the first person we are to hear from is Dr. Jones, who will have something to say about the medical aspects of the adoption law of the State of Maryland, Chapter 63 of the Acts of 1950.

Dr. Jones.

MEDICAL ASPECTS

GEORGEANNA SEEGAR JONES, M.D.[1]

Thank you, Judge Moser, especially for the introduction.

I was in Akron last week, and they were not so gentlemanly. They not only told my obstetrical history, but my age as well.

The medical problems involved in adoption are complicated by the fact that four individuals may be involved: the prospective mother, the baby, and the respective foster parents—a man and a woman. Thus, from a medical point of view, we may have involved an obstetrician, a pediatrician, a gynecologist and a urologist.

I am only a gynecologist, so perhaps some questions that may arise I will have to call on my colleagues to answer.

---

[1] Assistant Professor of Gynecology, The Johns Hopkins University School of Medicine, and Gynecologist at The Johns Hopkins Hospital.

For a logical presentation we will discuss first, the problems of the mother, then the baby, and finally those of the prospective adoptive parents.

Let us assume for illustrative purposes that the prospective mother is young, unmarried, and experiencing her first pregnancy. With this situation, the obstetrician is immediately aware that the situation demands care and attention, for in addition to the known hazards of a first pregnancy there are superimposed the emotional and psychological factors created by the situation in which the woman finds herself.

I say in addition to the hazards of a first pregnancy advisedly, because it is a statistical fact that the first pregnancy carries far more hazards than the subsequent pregnancies, until a parity of seven is reached.

What are the emotional aspects in this situation?

First not only her concern for her own physical well-being, which is real, and often important in any first pregnancy, but also concern for her financial assistance, which she must frequently care for herself. Second concern for the social stigmata which she brings upon herself and her family, and third concern for the welfare of her baby. All of these factors make for great emotional distress.

The careful conscientious obstetrician realizes he is facing a potentially difficult problem, as one of the most important complications of a first pregnancy is toxemia, followed by eclampsia. This condition is characterized, among other things, by an increased blood pressure, and many medical authorities believe that emotional factors play a part in hypertensive diseases and related disturbances. Thus the emotional make-up of the pregnant parent may be important.

Eclampsia may cost the life of the mother; if she survives, it may cause permanent disability and blindness in later life. Therefore from the standpoint of the mother, the medical care of the pregnancy is extremely important in order that the woman may be restored to society as a useful individual.

In addition to the medical problems of the mother that may arise during pregnancy, there are also potential complications for the baby. Probably the most controversial problem about the baby concerns the age at which it should be adopted. Everyone agrees that an adopted baby should be sound in mind and body, but there is a wide difference of opinion as to when this evaluation can be made. One of our most prominent authorities believes that such an evaluation can not be made until the child is one year old. Other equally capable authorities believe that if the pregnancy history and the type of delivery is known a capable pediatrician, observing a baby for as short an interval as three weeks, can make a fair estimate of its intellectual and physical capabilities. These are the two extreme views. The truth probably lies somewhere in between.

One must also be guided, of course, by practical aspects. It is frequently financially impractical to maintain a baby in a foster home for a period of as long as one year. Also, many pediatricians believe, from the baby's standpoint, that this may not be wise.

What are the pediatrician's major concerns for a baby that is to be considered for adoption? I am told that these are congenital abnormalities, and cerebral palsies, or related conditions. The congenital abnormalities, which include cardiac and gastro-intestinal abnormalities, blindness, deafness, and mongolism can often be diagnosed at birth, or shortly thereafter.

The cerebral palsies cannot always be detected so soon, but my pediatric associates tell me that if the pregnancy history and type of delivery is known, and the baby is observed carefully over a two or three weeks interval, these can frequently be at least suspected early in the life of the baby.

We have said that adequate obstetrical care is important from the point of view of the baby. And I repeat this, because it is a statistical fact that cerebral palsy occurs more commonly in babies after a history of a complicated pregnancy or delivery.

In discussing adoption problems with my prospective parents, I like to emphasize that although it is nice to know as much about the baby as possible, they are frequently too concerned with this aspect. I believe that the prospective parents are not looking only for an addition to their home, but they are in adopting a baby also contributing to the welfare of an individual. And I think they should keep this fact before them.

I like to cite the case of my friends in New York, an obstetrician and his wife, who knowingly adopted a handicapped child, because they felt they were eminently suited to care for this child, and knew that it would not be considered suitable for adoption elsewhere. This, I think, is the true spirit of adoption.

Finally, we come to the problems of the adoptive parents. Usually but not always these are a sterile couple. I have known physicians who have considered a certain child would be best placed in a home with other children. But ordinarily we think of the sterile couple as being the most suitable for the adopted child.

The role of the physician is usually to evaluate the infertility or in other words the ability of the couple to produce a child of their own. As a background for this, I think it is an interesting fact to know that twelve per cent of all couples in the United States are judged to be involuntarily sterile. Of this twelve per cent, from twenty-five to thirty-five per cent could be helped with adequate medical care.

How is a medical evaluation of infertility made? Ordinarily it takes at least four office visits and five fundamental procedures to make an adequate estimation of infertility. The man as well as the woman must be examined, because although statistics vary from population group to population group, in the United States, it is estimated that infertility is caused by male factors in twenty-five per cent of the cases.

As psychosomatic aspects are known to be involved in infertility, it is extremely important for the physician to assess the emotional stability as well as the physical status of both individuals involved. Thus it can be seen that if the physician has satisfactorily evaluated a couple for infertility, he should have a good knowledge of their physical, intellectual and emotional capacities.

In making a prognosis, the medical factors involved in infertility are judged as either absolute or relative. The absolute factors are those which preclude a pregnancy absolutely; absence of ovum or ovulation, the absence of sperm, and tubal blockage. Such absolute factors are estimated to play a part in the infertile couple in less than ten per cent of the couples, therefore from the medical point of view, ninety per cent of the couples must be judged as relatively fertile.

But the prognosis isn't made on the basis of medical factors alone. There are two other statistical facts which help us enormously. These are, first, the duration of the marriage, and, second, the age of the individual. If the couple has been married for one year, we know statistically that they have a fifty per cent chance of achieving pregnancy. If they have been married for three years without a pregnancy, their chances have fallen to six per cent. And if they have been married for six years with no pregnancy, their chances have fallen to less than one per cent.

The age of the wife is important, for it has been shown that women marrying under the age of twenty years are only five per cent infertile. Women marrying between the ages of thirty-five and forty are thirty per cent infertile. And women marrying after the age of forty are seventy per cent infertile. Therefore after the age of thirty-five, infertility increases rapidly.

Thus, in making an evaluation of infertility, we judge the medical factors, duration of the marriage and age of the wife.

In summary, then, I can say that it seems obvious that all four individuals intimately concerned with adoption have or may have major medical problems.

What is the role of the physician under the present Maryland adoption laws, when he is consulted either by the mother who presents herself pregnant asking for help, or by the sterile couple who has been judged as suitable for adoption? As I understand it, the physician can supply a list of licensed agencies—simply this and nothing more.

Judge Moser: Thank you very much, Dr. Jones. Of course, the very obvious questions here, I am sure, occurred to everyone here, after Dr. Jones has given the quite scientific and absolute answer within the range of percentages which were mentioned. They are: No. 1. Is this the kind of child that would be acceptable for adoption in the normal household, in the average household. No. 2, are the couple seeking merely to supply the mother another home for the child, and can that couple be given definite advice as to whether the infertility that has brought about their need and desire, a real or a passing thing. I was rather surprised that Dr. Jones did not go further and say the medical profession can supply this home as a part of the picture.

I am sure that there are many other things that touch on the new law, the answer to which will be given by the next speaker, who is Mr. Waxter.

SOCIAL ASPECTS

MR. THOMAS J. S. WAXTER[1]

It is like Old Home Week, tonight. And I am saying this because I see at least six other people in the audience who share with Judge Moser and myself the fact that we went to Public School No. 61. Herman was the bright boy of our class. I don't know whether he still maintains this distinction. And then when I got into college I ran into Mr. Anderson. He was the bright boy in my college class. I can say this, as some indication of the age of Doctor Jones that Judge Moser, Andy Anderson and myself are old enough to be the Doctor's father.

You know that I approach our problem from a different viewpoint than Dr. Jones. The whole impetus of my feeling about children and adoption is just to focus upon the child, and forget about everything else except what is good for the particular child. The triangle of the young parent, the adoptive parents, and the care to be given the child is perfectly clear—and the only one of the three that is entirely dependent upon what we do, and the one that can have nothing at all to do with what happens to him or her is the child.

There has been an old, old problem in Maryland about adoption. I would just like to very sketchily fill in a few gaps about what has happened in the state in recent years.

I had an old friend years ago who practiced medicine, a physician by the name of Dr. George Walker. He was a very successful physician, but he was a very aggressive sort of a fellow. I remember one time—and let us count this out, don't take it off of my fifteen minutes—he was a member of the Board of the Welfare Department, and we were going down to the City Hospitals on Eastern Avenue. On the way down we came across a small circus, and there was a man there with a balloon hitched to a rope. Walker went over to the man and he said, "How much will you charge to put me up in that balloon and cut the rope and see where we go?" The man said, $100. Dr. Walker and I got down there the next morning, at three o'clock in the morning, it was dark, and Dr. Walker, who was then in his 60s, got in to the balloon. Away they went up in the air. That evening I got a telegram from Dr. Walker, saying that he had landed up near Wilkes-Barre.

Well, it seems that Dr. Walker, with Dr. Howard A. Kelly, back about 1912 or '14, became much concerned in Baltimore as to what was happening with babies, and particularly what was happening in the field of adoption.

---

[1] Director, Department of Public Welfare of Baltimore City. (On September 11, 1953, Mr. Waxter was appointed Director, State Department of Public Welfare.)

They brought a person in from Philadelphia to do a study of the Baltimore situation. This man, with the help of Dr. Kelly and Dr. Walker, wrote the little book that some of you know of, called "Babies in Baltimore." They found that Baltimore was in those days called a lying-in city. Girls would come from all over the East Coast to Baltimore to have their children, and the children would be adopted out to people in the community. Baltimore was well known as the place in this part of the nation, to go to have your child, to get rid of your child and to go home. Out of the study came what was known as the 1916 Law, the Six Months Law.

The law tried to do something about people just having babies in Baltimore, indiscriminately, and putting them out to adoption without any rhyme or reason, except that it was the convenient thing to do. Under the Six Months Law of 1916, a mother had to stay with her newborn baby for six months, unless two doctors certified that it was necessary for the physical health of the mother that the mother and child be separated, or unless the State Department of Welfare certified that for social reasons it was desirable for the two to separate.

The law remained on the books until the mid '40s, '47 I believe, when the Maryland Legislature repealed it and enacted in place of it what is known, or what was known at that time as a Registration Law.

Under this Registration Law no one in Maryland could place a child with non-related people unless the fact of placement was registered. In other words, neither the mother nor anyone else could take the child and put that child into the custody of non-related people unless they registered the fact that they were placing the child with the State Department of Welfare.

The Registration law was an extremely difficult law to enforce. The Legislature in 1950, repealed it and enacted nothing in its place except to see that the adoption law was changed so that in the mind of the Legislature at least only a mother could place the child with a non-related person.

The volume of adoptions in Baltimore has grown rapidly. Gerald Monsman of the Legal Aid Bureau, made a study of adoptions for a committee appointed by Governor O'Conor in 1947. This study found that in Baltimore City roughly there were about four hundred adoptions going through each year. Of the four hundred adoptions in 1947, not quite half were with related individuals, and did not need the protection of a strict adoption law. The adoptive parents were people who were related to the mother. However, with the other half, something over two hundred adoptions that year that went through the courts, only about ten per cent were agency adoptions, and the other ninety per cent were made without the benefit of an agency.

Since then there has been an increase in the number of children being adopted, largely due, it is thought, to the fact that all over the country we have been having newspaper articles about adoptions. Life Magazine ran a series of articles about adopting children, which went through all the processes of how adoptions were made in various communities in the country. The New Yorker probably ran the best of the popular articles on adoptions in three series in March of 1951. Since the war there has been a definite upsurge in the number of adoptions throughout the nation. It is estimated—and this is the estimate of a New York agency—that approximately one out of every thousand families in America has an adopted child or adopted children. And generally throughout the country of these adoptions made, about forty per cent are with relatives and sixty per cent are with non-relatives. In total about twenty per cent are made through children's agencies.

Let me give you the reasons, as I see them, why we should have a strict adoption law. Very specifically the law should provide that where children are adopted into non-related families, that is, where the adoptive parents are not related to the child, in every instance they should be handled through children's agencies. In other words, the only way that you should be able to adopt the child in Maryland into a non-related family is through using the facilities of a children's agency.

I know that some doctors, a good many doctors, feel that they are more competent to arrange for adoptions than social agencies. I know that there are a good many lawyers that feel that they, too, are as qualified certainly as the social worker or the doctor to make arrangements for adoptions. But it just is not true. And the reasons for it are pretty obvious.

First of all, no one outside of the licensed child care agency has the necessary implements to do a satisfactory job. As a matter of timing only, the agency has the resource for taking the child at birth and making arrangements for the placement of that child in neutral surroundings, so that the child can be studied over a period of time. And we pretty well know what kind of kid we have before any commitments are made.

Some doctors feel that they can know a good deal about a child in a few weeks. Another group feels that it takes a year, according to Dr. Jones, and she suggests that the truth may be somewhere between the two.

Well, neither the doctor nor the lawyer have any facilities whatsoever to keep that child in neutral surroundings, without any commitments being made until it can be determined exactly what kind of child we have.

Secondly—and this second point is recognized in the Maryland law specifically—the law makes it mandatory that you cannot get a consent that is binding from the mother until after the baby is thirty days old. In other words, the law takes a dim view of the matter of making a commitment before the child is born, or immediately after the child is born. Certainly the average mother who has had a child out of wedlock is in no emotional condition to make commitments that are binding upon the child and binding upon herself immediately before, or immediately after, the birth of the child. And that time factor is of tremendous significance.

Thirdly: There is no reason in God's world why the friends or acquaintances of any doctor or lawyer should have priority in being selected as adoptive parents. It is not a matter of adults having priority. The priority is for the child. The agency, a recognized good agency in the community, has a long list of possible adoption homes. And it is possible to match the child against the home out of all relationship to the situation that any doctor or any lawyer can have.

And let me say right here and now that there may be doctors and there may be lawyers who can do a highly effective job on adoptions, but this certainly does not mean the entire medical profession and the entire legal profession. And in order to rule out one person, you have to rule out the whole group.

Fourthly: It is a fact that only the agency can really follow the child and the adoptive parents over a period of time. After the child is placed with the prospective adoptive parents, there is no way for the physician or the lawyer to follow the situation for say six months or a year before any papers are filed. No one has the time except the agency, and no one has the resources to accept the child back into its care if it is found that this child is not a good risk, that it is not a good risk for the child to leave the child in that home, either for something in the nature of the child, or with the parent.

And then, and lastly, the skilled social worker who is working with infants over a period of time develops a special skill in this whole adoption process that the lawyers do not have and that the doctors do not have, and we should keep within our own areas of competence. Then, too, only the social worker can bring all the various forces and agencies together.

Now, I certainly don't go to a social worker if I am in a bad way in the criminal courts. I go to Andy Anderson. And I don't go to a social worker if I have to have an operation for appendicitis, and I don't go to Dr. Jones either, but I go to a general surgeon.

I would like to have the community accept the fact that there is a real specialized and high technical skill possessed by the social workers' profession, and that social workers have something which is very real when it comes to working with children in the adoption process.

And finally I believe far more—and you, Dr Jones, have convinced me of this—that the agency, of all the ways in which children can be adopted, the agency is going to be the place where the focus is upon the child, it is not upon the mother, it is not upon the adoptive parents, but it is on the child, and what is best for that kid. This is what I am pleading for, regardless of what the present law may be.

And I would like to make a suggestion, and that is that the Bar Association and the City Medical Society appoint a small joint committee, infiltrated with a social worker or so, and that the committee try to draw the kind of adoption law that we want for Maryland and then go down to the Legislature and see that children are properly protected.

Judge Moser: There is no such thing as permanence or perfection, and there is certainly no such thing as permanent perfection. And I am perfectly sure, for that good reason, that the law of 1950 could well stand, as was suggested by Mr. Waxter, a going over, a looking at, and a careful examining, and perhaps that may give us something that is better.

There were several thoughts that occurred to me as Mr. Waxter was speaking. The main and really the only point involved in the saying of "yes" or "no" to an adoption is when is it best for the welfare of the child. And then why is there any distinction, or why should there be any distinction between related and unrelated adoptive parents? If the only question that should be before the court is the welfare of the child, then why can a mother determine that without aid better than anyone else?

I am just posing those questions. I don't know whether they are good questions or not, but obviously there are many ramifications to this.

I am aware of the thirty days period that you speak of after the birth of the child that would invalidate consent, but I also am perfectly sure that a court would take into consideration, if a mother filed a petition to set aside her consent before the birth of the child, or on some period after 30 days if her circumstances mentally were such that she was not aware of the full implication of what she was doing.

There are some other things, but I will wait for the question period for them.

We are now about to hear from one of those who admittedly, I am sure, will tell you that he is not qualified to say whether or not a child should or should not be adopted, but whom I am also sure, from recent experience I had with him in court, has some very positive ideas as to whether or not this law is the right or correct way of going about protecting the interests of the child, and whether or not the law is a good law, and whether or not it is even a constitutional law.

We are now going to hear from Mr. Anderson.

LEGAL ASPECTS

G. C. A. ANDERSON, ESQUIRE[1]

Judge Moser, members of the Panel, Ladies and Gentlemen:

I am not here to attempt an evaluation of the various social factors that may be involved in this particular question. I am here for one special purpose. I feel strongly about that purpose.

I want the public to understand the drastic character of the law now in force and effect in Maryland, and more particularly, I want doctors and lawyers to understand their rights, duties and obligations under that law, being Chapter 63 of the Acts of 1950 of the General Assembly of Maryland.

My story starts in 1945. In 1945 a delegation from Montgomery County went to the Legislature; this delegation urged the Legislature to amend the existing adoption laws. Montgomery County is near Washington, and the County was having trouble with the adoption laws, and the adoption of children. During the same session, a delegation from Baltimore visited the Legislature. This delegation also wanted to make some amendments to the adoption laws. The two delegations decided to pool their resources. Under their sponsorship a Resolution was passed by the House of Delegates under which a committee was duly appointed by Governor O'Conor, headed by His Honor Judge Eugene O'Dunne of the Supreme Bench of Baltimore City, as Chairman, and Mr. Gerald Monsman of the Legal Aid Bureau, as Secretary. This Committee was directed to make a study, report to the next Legislature, and propose for enactment by the Legislature such laws as the Committee deemed advisable.

---

[1] Past President of the Bar Association of Baltimore City.

The next Legislature in 1947, at the suggestion of this Committee, enacted Chapter 599 and Chapter 600 of the Acts of 1947. For the purposes of this discussion, I am only interested in Chapter 600.

It was the purpose of this Act to grant the State Board of Public Welfare rather complete authority and jurisdiction over the adoption and custody of unwanted and homeless children. Specifically it provided: (a) that all agencies or individuals having the care, custody or control of minor children; (b) that all institutions and individuals who act as child placement agencies for adoption, and (c) all individuals who regularly engage in the business of providing foster homes, were required to have a license. The law went on to provide that all individuals or agencies violating these provisions of the Act were subject to a fine or prison sentence. Thus we start with the theory that any person acting as a placement or adoption agency must have a license.

You will note two significant facts about this Act. The Act generally would control the adoption of children through the licensing of adoption agencies, but it did not specifically prohibit a mother from arranging for the adoption of her own child.

As might be anticipated, the Act was difficult to enforce. The prohibition ran against a "placement agency." A distraught mother and lawyer, or a distraught mother and doctor or clergyman was scarcely such an agency.

What happened? As you have already been told by Dr. Jones, in a first pregnancy, the mother is often unduly worried and frightened. To this add the fact that she is unwed. Often, in a near panic, she asks for help. Her request may be directed to her doctor, a member of her family, a lawyer to whom she turns for advice, or a friend. It often takes the form of "Can't you find somebody who will adopt my child?" If a home is found for the unwanted child by the mother with the help of her doctor or lawyer, such action by the mother in an isolated case, or by a doctor or lawyer in several cases, scarcely turns the mother and the doctor or lawyer into a placement agency. Since placement agencies alone were prohibited from the placing of children without a license, it followed that many children placed by the mother, with the help of a doctor or lawyer, were adopted without a license.

For good or for evil, it was believed that this was a serious defect in the law. The matter was brought to the attention of the Legislative Counsel and the present Act, being Chapter 63 of the Acts of 1950, was the result.

This Act of 1950 provides as follows:

> "... the placement of a child by anyone other than a licensed child placement agency, local Department of Welfare"—[and here is the joker]—"or the child's natural parent or parents, grandparents, or the child's natural parents, adult brothers or sisters, is prohibited."

Thus ... adoption of children is prohibited unless ... done through a placement agency or, ... quote, "the child's natural parent or parents."

It was very kind of Dr. Jones a moment ago to say that children could only be adopted through placement agencies. When I first discussed this law with her, she advised me somewhat as follows: "You don't know what you are talking about, here is what it says—it says that the child can be adopted, or can be placed by a natural parent."

But the question is, what does the Act mean when it says there can be a placement of the child by the child's natural parents, grandparents, adult brothers or sisters?

The Act is primarily a model Act. It had its origin in New Jersey, and has been copied by some seven or eight different states along the Atlantic Seaboard, including the District of Columbia.

The leading appellant case is to be found in the District of Columbia, and is known as the *Goodman case*, reported in 50 Atlantic (2d) 812.

In this case, a woman went to a lawyer for the purpose of getting a divorce. She was pregnant at the time, and wanted to be sure her child was placed in a good home. She requested her attorney to look for a home. He refused, but suggested that she go to one of several recognized placement agencies in the District. She had been brought up in an orphanage and apparently was fearful of such agencies. At any rate, she refused such advice, and persisted in requesting the attorney to assist her. The record in the case shows that approximately twice every week this woman called the lawyer requesting him to look for a home for the child. He persistently refused her request.

She was about seven months pregnant when, becoming desperate over her situation, she insisted that her attorney take some action in the matter. He finally acceded to her request; he looked around and found some people who were interested in taking this child. He arranged for the adoption. The child was adopted. And that was that.

Some time went by, and the natural mother changed her mind, brought the matter to the attention of the authorities, and the lawyer was indicted for violating the law, in that, he had been guilty of an act of placement. It was admitted that he did not get a dime for what he did. It was further admitted that everything he did, he did for purely humanitarian purposes. It was further admitted that everything he did, he did only because of the mother's insistence.

The court held that motives were immaterial, that since he had assisted in the placement of the child, such assistance constituted a violation of the Act, since a child can only be placed by a placement agency, or the mother acting alone without the assistance of any one. All of which means that the mother herself must contact the adopting parents and conduct all the arrangements leading up to the adoption. To aid or assist the mother is to violate the law. At page 814, the Court said:

> ". . . that Appellant (the lawyer) did these things without compensation, that he was animated by the most humane motives, that he was perhaps imposed upon by the mother or yielded in sheer pity to her cries of distress—all this we may concede. *And all this appeals to our sympathy for him; but it cannot justify us in holding that his acts were within the law.*" (italics supplied).

Such a law violates a rather general pattern of conduct that has been followed in Maryland for a great many years. It has often been the custom and habit of doctors and lawyers, if asked by the natural mother, to place or arrange for the adoption of the child, or at the very least to aid and assist in the adoption, after some one else has made the contact between the mother and the adopting parents.

Lawyers did it, doctors did it, and probably many other people, acting with the best of motives, participated in the adoption before it was concluded. In the more rural counties of Maryland today, the law is honored in its breach.

There was a recent case in Maryland which went to this extreme. A Maryland doctor was visited by his brother-in-law from New York. In the course of conversation, the brother-in-law remarked that the doctor, in the course of his rather extensive general practice, might know of an unwed mother who wished to place her child in a good home; that he had some friends who had been married for ten years and who were very anxious to adopt a child; that should such a case be brought to the attention of the doctor, would he be good enough to drop him a note. Without thought, the Doctor said he would. Some time went by. I have forgotten exactly how long,—perhaps a year or a year and a half, when the Doctor, in the course of his practice, was called to treat a woman who was very anxious to obtain a home for her unborn illegitimate child. The Doctor wrote his brother-in-law, and shortly thereafter received a long distance telephone call from the married couple who wanted to adopt a child.

Over the week-end, this couple came to Baltimore and the entire matter was investigated and discussed at some length. The child was born and the Doctor notified the adopting parents. They wired the Doctor that their lawyer was coming to Baltimore. He met the lawyer, introduced him to the mother, and the adoption was arranged. That is how a contact was made. He was indicted, tried and found guilty of violating the law.*

My point is that I want the public, the doctors, and the lawyers to understand the drastic character of the law. To date there has been in Baltimore this one case under the new law, which case was in the nature of a test case. This test case has placed the public, the medical profession and the legal profession on notice. Ignorance is never an excuse, and henceforth it cannot be used as an excuse even to mitigate punishment.

Thank you very much.

Judge Moser: Ladies and gentlemen, we are going to have a very few minutes recess, but before we do I would like to make several comments.

I am in thorough accord with what has been said by all the speakers, and particularly by Mr. Waxter and Mr. Anderson—in their comments on the law, that is—that it is probably not understood.

I must confess that when the first case was brought before me, I was distinctly surprised to find out that was the law. I had no idea that it was. I could be wrong about it, too. At least, that was my best guess.

And in looking around, I am hoping that none of you came here this evening for immunity, but for information.

However, before we feel too sorry for some of those who have violated this law—and may I confess also that unlike Mr. Waxter, who can speak of his association and championship of the Department of Social Service and Social Service for Children here in the community, for which the community should be eternally grateful to him—unlike Mr. Waxter, who said he has no bias for social workers, I confess that I have a bias for lawyers —but not for the lawyer in this particular case who, according to the information which I have, went to doctors, and received fees up to $4500 for producing babies for adoption.

We are going to have a four or five minutes recess, wherein those members of the audience who desire to write out questions which they would like to have answered by any of the discussants may do so. Mr. Waters, if you will sort of separate them, then we can discuss them. So we will recess for just a few moments.

(A short recess was then taken.)

QUESTION AND ANSWER PERIOD

Judge Moser: Take your seats, so that we can continue.

I am delighted at one thing, and that is we have received many more questions than we will have time to give you the answers. I am delighted that you have asked so many questions. Unfortunately, if we don't answer the particular questions which you desire the answers to, I want to apologize for that fact, and I want to assure you that it is not because we do not want to, but because we have not the time to answer your questions.

I would like to inform the discussants that they will be allowed, except by special dispensation, three minutes to answer each of these questions. I have several here that I wanted to start something with, but I am going to submit those in just a little while. I am going to get these other things out of the way first.

---

* For further discussion of this matter, see Daily Record of sixth day of April, 1953.

Q. There are two questions that can be asked together. One, "Please state the list of placement agencies that the doctor may mention to the mother," which I think is an excellent question, and along with that is another question which is along the same line, but which goes a little farther, and that is, "Please give the method, step by step, whereby one without violating the law"—and that means a doctor, or a lawyer, or an individual other than the mother —"whereby one without violating the law may take part in the adoption process?"

I think, Mr. Waxter, I will let you give the answer to this. I know you are more familiar with the placement agencies than any of the other discussants.

MR. WAXTER: In Maryland, a child placement agency must be licensed by the State Department of Welfare. In other words, an association goes to the State Department of Welfare, files a request for a license, they are studied by the Department, and then a license is granted.

In Baltimore the three big private agencies are The Jewish Family and Children's Bureau, the Associated Catholic Charities, and the Family and Children's Society of the Community Fund. Probably the Church Mission Society, which is an organization of the Episcopal Church, provides for as many adoptions as any of the smaller organizations. And the Department of Welfare of Baltimore City also provides adoptions service.

Individuals can be directed to any of the agencies that I have mentioned. There are others besides those I mentioned. They are listed by the State Welfare Department.

Under the present law, there is nothing to stop a mother herself in making all arrangements for adoption and in doing everything that she can up to the time that the petition is filed in court. Under the present Maryland law, the mother has complete freedom in placing the child anywhere she wants to, but the difficulty comes, as I understand it if in any way a doctor or a lawyer, no matter how innocently, participates in the matter of the selection of that home, or having anything to do with the home.

Isn't that right, Andy?

MR. ANDERSON: That is right.

MR. WAXTER: I think that is really the essence of what you say.

And I think the proper way, step by step, is for the mother to go to a social agency, to work with that agency that already has a list of the possible adoptive homes and to work with the agency towards having her child placed, if that is the desirable thing for the child and for the mother.

Now, let me interject this one thing. There are a great many mothers, small percentage wise, but in the total nation large in number, who, if they made the decision, if they were forced to make a decision immediately before birth, or immediately after birth, would put their child out for adoption and release the child, but who actually, when they don't have to make a decision of that kind, work out some arrangement by which they keep the child with them, in other words, no adoption comes into being, because the mother has time enough to consider the whole problem and decides to keep that child with her.

JUDGE MOSER: Incidentally, Mr. Waxter, you answered the question by asking a question of Mr. Anderson. And one of the other questions was whether the introduction by someone other than the mother to the adoptive parent is a violation of the law. And it could very well be, as Mr. Anderson indicated.

Now, I would like to ask you several questions, Doctor, if you don't mind coming around here. I think if you will, we can all hear you better.

There are several questions here that I have been asked to ask you.

Q. The first question is, "Is there any medical evidence for the popular belief that the adoption of a baby is a cure for infertility?"

DR. JONES: That is one of the most frequent questions asked in a discussion of infertility. There was a study made on this subject two years ago in Boston. The answer is, no, there is no statistical evidence that adoption is a cure for infertility. Those individuals who adopt children have no more chance of having children of their own than infertile couples who do not adopt them.

Q. JUDGE MOSER: Now, I think I am going to start a little difficulty here. It is a little off the subject. But I am sure it is one about which the Doctor is very familiar. The question is, "Is artificial insemination practiced in Maryland, and what procedures are followed in its practice?" And I am telling Mr. Anderson that I am going to ask him another question thereafter, which I think is connected to it, "What legal implications may arise from the practice of artificial insemination?"

DR. JONES: Yes, artificial insemination is practiced in Maryland.

I think we should define artificial insemination, because actually there are two types. One is with a donor's semen and the other type of artificial insemination is with the husband's sperm.

The latter is practiced I think in Maryland much more commonly than artificial insemination with a donor. But it also is done. Although there is a wide difference of opinion as to the advisability of this. I think that certainly the physicians in Baltimore who do this do it only at the request of both individuals—the husband and the wife. I think it is also a procedure that is usually not suggested by the physician. I personally would never consider suggesting it. But I have done it on request.

It is asked, what procedures are followed. Does that mean medical procedures or law procedures?

JUDGE MOSER: Medical. Unless you care to go out on the limb.

DR. JONES: Artificial insemination with the husband's semen is practiced only when there is some anatomical abnormality, or some reason to believe that with a concentration of semen the sperm count may be sufficiently raised to effect a pregnancy. It is quite a technical medical procedure.

In donor artificial insemination getting the donor is the major difficulty, because we must be assured that the donor is a superior person with a good medical background. One must go into his history just as you would your patient's history. You have to know whether he has any congenital abnormalities in his family, or any hereditary diseases such as diabetes, as we prefer to use only men who have high contributions to make. This, of course, makes procurement very difficult. We ordinarily recruit our donors from the hospital staffs or medical schools.

It is always surprising to me how reticent men are about making such contributions. And I think it is an excellent characteristic. It shows their feeling of responsibility to their progeny. Even though they may never know them, they still feel a great personal pride in this, and I think it is a good thing.

When I perform artificial insemination, I use three donors on three separate days, so that I don't know actually who has made the successful contribution. And I don't keep any records of any donors, either.

Another thing that I always do, and that is recommended by the American Medical Association: I have a little paper which I get both the husband and the wife to sign, saying that they are fully aware of what has taken place and that the child will be legally adopted. I understand that it is important that the child be legally adopted to clarify its status.

Does that answer the question? There are many aspects to this.

JUDGE MOSER: I am sure that it was interesting, at least to the legal part of the audience, who have little knowledge of it. It is the kind of topic, too, perhaps about which no comment should be made except by those who know about it.

Q. Now, Mr. Anderson, do you care to comment about some of the legal effects that might flow from this? In fact, another question that is asked is with reference to the legal status of a child conceived by artificial insemination, which I think was answered by the Doctor, in which she said there are adoptive procedures which remove the possibility of there being any question as to the status of the child legally.

Incidentally, do you feel you are on the hook a little bit here, because you were not aware of this? And if you want to think about it for one minute, there is another question asked that you may answer in connection with this one, and which has absolutely no connection with it, "What specifically are the changes which you would advocate in the law which you say is of such a drastic character?"

MR. ANDERSON: Well, I will take the first one first.

I know of no actual case. There was a paper delivered to a panel somewhat like this panel in Chicago, the gentleman who delivered that paper made the same kind of a general statement that I am about to make.

You must remember that when dealing with adoption, you are dealing purely with statutory law. All rights that flow from adoption proceedings are a result of statute. Adoption is unknown to the common law. It was known to the Roman law, but unknown to the common law. Therefore, there is no common law precedent. Thus, whatever the rights, and whatever the duties and obligations, they must be determined by statute.

I am sure that when the adoption statutes were passed, the original statute in Maryland was passed in 1892, nobody had any thought in mind of this particular kind of problem.

It was the conclusion of the gentleman who read the paper in Chicago, and I think it is a proper conclusion, predicated again on the statutes themselves, that the status of the child would probably be that of a bastard. As a bastard, of course, he would lose all the rights which attach to a natural child, as distinguished from a bastard child. I believe that under those circumstances, the only safe thing to do, and it apparently is the practice, is to later have the child legally adopted, to be sure that the child has the status of a natural child.

Q. The other question was: What would I do about the law in Maryland if I had anything to do with it?*

Well, I don't know just what I would do, except I would try to clarify the Act so that any one reading the Act could clearly and easily, from the terms of the Act itself, know what was a violation of the Act and what was not a violation of the Act.

Because of what I believe to be its ambiguity, I have argued strenuously with Judge Moser that the Act is unconstitutional. It is a fundamental constitutional concept that you are supposed to be able to look at a statute, and particularly a criminal statute, and know whether you have violated the same.

If the Act is as drastic as the Courts have interpreted it to be, then it seems to me that the statute itself ought to be crystal clear. That, I submit, is not the case with the present Act.

Q. JUDGE MOSER: Before you sit down, Mr. Anderson, do you mind answering this one other question? "What is the law as it affects the adoption of a person over twenty-one?"

MR. ANDERSON: People over twenty-one can be adopted exactly the same as people under twenty-one.

The age of the person has nothing to do with it.

Q. JUDGE MOSER: Mr. Waxter, I have a question here that I think is one that you are probably in a position to answer. The question is, "What specifically is the special skill that a social worker acquires—what tests do they use on infant children to determine their adoptability?" I put that question to you, Mr. Waxter.

MR. WAXTER: I would like to say a few words about the new adoption law.

---

* Governor McKeldin has recently appointed a Committee, with His Honor Judge Moser, Chairman of this Panel Discussion to study the adoption laws and make such recommendation as it deems proper.

If we are going to have a new adoption law, I would like to see the best minds in the law and in medicine and in social work sit down and consider the problem of adoption, yes, but adoption, after all, is only one method that we have evolved in society for taking care of a large number of children who either have no homes of their own, or who need homes other than the homes that they have—adoption is one method of doing that—and it takes care of and drains off a few of the children who do not have proper homes of their own.

Now, then, along with any adoption law, we should have in Maryland something that protects the large number of children, probably more than are adopted in any one year, who are living outside of the circles of people who are kin to them. There is a lot of passing along of children in Maryland, and certainly a lot of it in the Negro communities, where somebody has a child and they give it to somebody else, and there is never a formal adoption process that takes place. I think we ought to sit down and find out what the State should give to children in the way of protection, so that when they go to live with unrelated people, that the State knows what is going on, and that the State has some assuredness that the kid is getting an even break in life.

That was the thesis of the Six Months Law, to give time to consider the whole matter, and make it necessary for two doctors or for the State Department of Welfare to say that the mother should be separated from the child. It was certainly the object of the Legislature that no child could be placed with a non-related person unless the fact was noted and registered with the public authorities. This Act was wiped out without putting anything in its place. It is wide open as of the present time. We should have something in the law that stands side by side with the adoption law, that would guarantee to children that when they are placed in a home by their mother or by anyone else that the State looks at that situation, to be sure that the child gets minimal protection.

Now, let us go back to what skill the social worker has that a lawyer does not have and a doctor does not have. It is the same thing as asking the doctor what does the doctor have and what is the science of medicine and the same thing as asking the lawyer what is the science of the law. And here I may say this to you, that there are skills in working with people —and certainly all of you know this—there are skills in working with people that have been developed as a process over the years, and there are ways of understanding children and working with them and developing a technique that can be very useful and effective.

One of the difficulties with social work it seems to me is the inability to put into precise words what social case work means; what it means to understand people and to help them work out their problems by understanding the problems of the individual and helping him.

I would like to have that answered much more adequately than I can answer it. I would like to have it answered by a professional social worker. There are a lot of them in this room.

Q. JUDGE MOSER: Before you sit down, here is another question that was asked, "Would it be good policy, that social agencies give preference, all things being equal, I presume, considering the welfare of the child, to those parents who are not fertile?"

MR. WAXTER: Let me say this. The Baltimore Council of Social Agencies publishes a quarterly. The last issue was in December of 1952. They had three social workers in Baltimore who wrote in the December issue about adoption: one from the point of view of the real mother, one from the point of view of the child, and one from the point of view of the adoptive parents. These articles do an awfully good job in presenting the points of view of the three corners of the triangle, and what social work does in trying to work out what is best for all three parts of the triangle, but with the principle focus on the child. This publication is available to anyone interested in the problem.

Frankly, I don't see why any group of potential adoptive parents should be given priority over another group. The thesis that I am trying to develop is that the focus should always be on the child and not on the adoptive parents. And no one ought to have priority in this matter of adoption except the child itself.

Q. JUDGE MOSER: There is a question that was handed up, and as it was passed along, in all seriousness, I assume that someone desires it to be answered, but whom I should ask to answer it I am somewhat at a loss to determine. It says, "Who would you consider the father in the illustration cited by Dr. Jones, of the three donors?"

DR. JONES: I can answer that.

JUDGE MOSER: I will permit you to answer it, Doctor.

DR. JONES: I consider the father the man who has made the largest contribution—the husband of the wife.

JUDGE MOSER: There are many, many other questions that have been submitted, and I am sure that it would be quite interesting to get the slant of the discussants on many of them. For example, "Is it a good psychological policy for the real mother and the adoptive parents to know each other?" Of course, normally they don't know each other. Normally, they don't come in contact with each other.

Here is another question that was asked, which points out some of the things that are done. The question was, "What information does the court have before it when it signs the adoption papers?"

Well, the court has all the background that has been discussed by Mr. Waxter and by Dr. Jones. It also has its own agency, it has its own probation department, which makes an investigation and which reports thoroughly on all of the aspects—the health of the child, the health of the adoptive parents, the reason for the mother wanting to have the adoption occur. And it is a very voluminous and very thorough report.

I see in the audience here one of those who has the responsibility for seeing that those reports are as thorough and are as carefully prepared as they are—Mr. McDermott of the Circuit Court, for Juvenile Causes, where the investigations are now made when the court is asked to sign the adoption decree.

Of course, there is no law, as I say, that cannot be improved upon. And perhaps out of this discussion this evening may come the necessary impetus to do two things, as I suggested at the beginning.

First, to make sure that those who come in contact with persons who desire to avail themselves of the law—and primarily the doctors, the lawyers, and social workers—thoroughly understand the law with which they have to deal. You may say that it does not seem right, that a grandparent or a brother or sister be in any better position to place the child than a placement agency. And they are questions that serious-minded persons may well discuss, and it may be that out of these discussions will come a better understanding of the law as it is.

And, secondly, I believe that if a better law can be placed upon the statute books, then I am sure that the community will owe a debt of thanks, not only to these discussants here this evening who have helped to bring it to you, but to the two Bar Associations and the Medical and Chirurgical Society that have made this interesting evening, to me at least, possible.

I thank you.

Scientific Papers

MANAGEMENT OF CONVALESCENCE AND LATER LIFE AFTER CORONARY THROMBOSIS*

WILLIAM S. LOVE, M.D.†

Coronary occlusion is said to be present in 40% of all autopsies in males above the age of 50. Such occlusion may have symptomatically appeared explosively with myocardial infarction but, except when due to trauma in younger individuals or to the rare case of embolism, the underlying disease process has been of gradual development. This process is arteriosclerosis of the coronary arteries. Certainly in most instances it has been present long before myocardial infarction may have occurred. This fact should influence our thinking in two ways in regard to the patient who has suffered infarction—first, that he has offered definite evidence of the existence of chronic arterial disease that will persist even though the acute symptoms subside, and that may again undergo acute exacerbations; and secondly, we may be cheered somewhat by the thought that many others in the patient's age group also have arteriosclerosis, but will never suffer clinically acute myocardial infarction—perhaps it will not occur again in our patient.

Let us consider the patient who has made a good clinical recovery from myocardial infarction and who has no complications. It would seem obvious to me that our objective should be to get him back to as normal a life as rapidly as possible as is consistent with a reasonable degree of safety. The average patient who is doing well can be permitted moderate activities such as moving about freely in bed, using a commode etc. from the beginning, and can usually leave the hospital by the end of his third week, if not sooner. To keep such a patient indefinitely at rest at home only encourages the development of fears and apprehensions that may be more crippling than the condition for which he is being treated. Therefore, in this type of patient, I like to have them back at part-time work not longer than two months after the onset of the illness, providing such work does not entail any strenuous physical activity. Furthermore, some degree of activity promotes the development of collateral circulation between the branches of the coronaries—indeed, such collateral circulation develops in response to the narrowing of the arteries by sclerotic placques, and if occlusion takes place gradually, may be functionally adequate to prevent infarction. However, I prefer that they not participate in any physically active games, such as golf (never tennis) for at least a year. By that time what anastomosis between the coronary arteries that will develop can be expected to have done so. These activities should be permitted only to those who have no complications and no apparent limitation of cardiac reserve.

In these patients I believe that there are several ways of attempting to prevent recurrence of the infarction. First, they (and probably all of their age group if over 50) should avoid strenuous or violent physical exertion, or exertion of an unaccustomed degree. The majority of sudden occlusions of the coronary arteries are attributable to small subintimal hemorrhages which increase the size of arteriosclerotic placques, and may lead to thrombus formation distal to the point of narrowing. Contrary to earlier thought on the subject, most now agree that preceding such a train of events, a history of unaccustomed exertion, excitement, a blow on the chest, or other injury is usually present. Who of us hasn't seen such a case as this: a four or five inch snowfall overnight; the patient tries to shovel his way out of the garage; hurried and probably angry, he has a sudden crushing pain in the chest and has to sit down. In a few minutes he may feel all right and go to his office, only to have the pain return more severely hours or even a day or so later and when finally examined infarction is discovered. Therefore, these patients should be warned that as far as possible they should avoid such precipitating factors. Take the time to explain the situation to them. An understanding patient is usually a cooperative patient.

---

* Presented at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, Wednesday Morning, April 29, 1953, Osler Hall, Baltimore, Maryland.

† Associate Professor of Medicine and Chief of Section of Cardiology, University of Maryland School of Medicine.

I sometimes think of Christmas as the infarction season: overactivity, parties, late hours, and gluttonous eating. Another history I am sure that we have all heard is one that concerns the big dinner, the afternoon party and then the stop at the brother's home for a little snack and some beer—and often what a snack—and the awakening at four or five in the morning with indigestion that turns out to be infarction. Needless to say, these patients should be advised as to the possible consequences of such living, and advised to live normally and to eat modestly.

Another question in regard to diet and metabolism is being very actively investigated at present: this is the relationship of cholesterol and related lipids to the production of arteriosclerosis. It does not seem likely that cholesterol is the initiating factor in the causation of arteriosclerosis. However, it is quite possible, even probable, that disturbances in lipid metabolism with excessive blood concentrations thereof, lead to an increase in their deposition in the arteriosclerotic placques with consequent greater narrowing of the arteries. Therefore, I certainly believe at present that it is wise to advise low cholesterol, low fat diets in these patients; when overweight an active reducing regime is indicated and relatively low calorie diets are indicated in all such patients. The liver produces cholesterol and will do so on high calorie intake.

Now, all that we have discussed probably involves some restrictions of previous activities. I would like to suggest that you present these restrictions as a matter of sensible normal living, perhaps in contrast to a former abnormal way of life; that they are things that his friends who do not know that they have coronary disease would be better off for doing. While there occasionally may be times when one is justified in trying to frighten people into carrying out advice, this approach has a seriously deleterious effect on many.

The question next arises—are there any drugs which are of benefit? In the uncomplicated case, I doubt it. We will discuss in more detail such drugs as the nitrites, aminophylline, etc. when we speak of angina pectoris. We all use them in the hope that they may cause increased coronary flow and perhaps more rapid development of collateral and anastomotic channels; there is little evidence that they actually do so. Certainly, in uncomplicated cases, there is little reason to continue them indefinitely. That leaves us the anticoagulants. In my rather limited experience in using these drugs in the hope of preventing further episodes of infarction, I have not been impressed by their usefulness, and I believe that the majority of Cardiologists feel the same way. In amounts that may be considered safe for use away from daily prothrombin checks, there is little reason to believe them effective. Recall if you will that the acute occlusion usually begins with a subintimal hemorrhage. On several occasions in my experience, fresh infarction has occurred when the prothrombin time was adequately controlled by dicumarol. Even in the acute stage of infarction the value originally assessed to them is being questioned by some.

In regard to alcohol and tobacco, opinions vary. I do not feel that alcohol has been proved to be of value in dilating the coronary arteries—on the other hand, in moderation it is not harmful and may produce a feeling of relaxation and well being. During an acute episode, I try to forbid tobacco, but if the patient insists on smoking, it does not seem to me to be worth arguing about, and the argument succeeds only in creating emotional tensions.

The complications that are most apt to occur after an episode of infarction are:

1. Angina Pectoris—This symptom of coronary disease may have been present before the infarction occurred, or it may appear for the first time afterwards; or it may never be present. It indicates a recurring ischemia and is handled in about the same fashion under either circumstance. To my mind the most important matter for the doctor to consider is what brings on such attacks, and then have the patient avoid the precipitating factors. However, it is rare that anginal episodes can be completely avoided in a patient subject to them. For immediate relief, no new drug surpasses nitroglycerine. Other mixtures of nitrites, aminophylline, theobromine salts, Khellin, papaverine, etc., often seem to cut down the frequency of attacks and are worth trying, but they usually prove to be disappointing in the long run. Certainly reliance should not be placed upon them to the point of forgetting common sense advice to the patient. In the unfortunate patients who may become practically disabled by pain, surgery is not contraindicated, and such procedures as dorsal sympathectomy, production of a sterile pericarditis, or arteriolization of the coronary sinus should be considered. Remember that sympathectomy is not known to have any influence on the underlying disease—it merely interrupts the pain pathways and thus relieves a symptom. The production of a sterile pericarditis may effect a sufficient collateral circulation to be helpful. Arterialization of the Coronary Sinus is a serious operation that has given some dramatic results. To date it has not been performed with sufficient frequency and patients have not been followed for a long enough time afterwards to permit sound evaluation.

A train of symptoms often mistaken by both the doctor and the patient for pain of cardiac origin is the Shoulder-Arm syndrome. This consists of pain in the regions named, at times spreading to the chest, usually, in the patients discussed, occurring on the left side; the condition occasionally ends in obvious trophic disturbances of the hand and arm. In mild form, it is commonly noted after myocardial infarction and is differentiated from angina by its constancy, lack of relationship to effort, etc., and by pain on motion of the affected part. It can usually be controlled by the aspirin family, by local applications of heat, massage, and especially by encouraging the use of the arm and shoulder. If very severe, sympathectomy may become necessary. Cortisone has given contradictory results in the hands of different observers. It is important to reassure the patient that this is not angina pectoris.

Congestive heart failure may occur during the period of acute infarction, or it may come on later with increased activities or subsequent to progressive myocardial fibrosis. It should be handled as usual, except that one might express a word of caution in regard to the very rapid digitalization of such patients. They should be digitalized, but it is far safer to take a little more time to accomplish full digitalization—say 24 to 48 hours. These patients also require that careful consideration be given as to what activities are permissible.

As a result of extensive infarction, myocardial aneurysm may develop. It is worthwhile recognizing this, for in my experience these patients are more apt to develop other complications, such as failure or ventricular arrhythmias, and hence should be watched more closely. Such aneurysms may also be the source of embolization. I am seeing four such patients at present, and all have had episodes of failure; in two the failure occurred acutely during attacks of ventricular tachycardia. Nevertheless, at present they are all working at least part-time in executive or physically non-strenuous occupations. The Cardiologist can usually recognize this condition with his customary tools—the electrocardiogram and careful fluoroscopy.

A word about the arrhythmias is indicated. When auricular fibrillation occurs, bed rest and digitalization, if not already accomplished, will often lead to a cessation of the arrhythmia. If it does not, the situation is usually not serious for the ventricular rate as a rule can be satisfactorily controlled by digitalis; hence, I only try to restore sinus rhythm with drugs such as quinidine, when the patient's disability is obviously enhanced by the disturbance in rhythm and the ventricular rate cannot be controlled. Such patients are often difficult to "break," revert to fibrillation easily and may require maintenance dosage of quinidine that exceeds the bounds of safety. On the other hand, the paroxysmal tachycardias, because of the rapid ventricular rates which of themselves tend to enhance coronary insufficiency and may also bring about acute left ventricular failure and pulmonary edema, should be terminated as promptly as possible. For this purpose mechanical procedures such as carotid sinus stimulation may promptly end the arrhythmia; more often they will not. Quinidine still remains the most useful drug and may be given intravenously if the situation is critical. Pronestyl may be more effective if the tachycardia is known to be ventricular in origin and can also be used intravenously. I have had considerable success in the ventricular tachycardias with the intravenous use of suitable digitalis preparations; they can not be so used if the patient is already digitalized. I prefer one of the more rapidly eliminated glycosides, such as Ouabain.

Just a word about these patients and other illness. They have a lessened myocardial reserve and should be put at rest during an illness of any consequence that may throw an additional burden upon their circulation. They tolerate surgery less well than normal people, but necessary surgery should be performed. Perhaps I might mention one type of disease specifically—gall bladder disease. Correction of a diseased gall bladder has often improved the symptomatic status of these patients. I clearly recall two patients with past infarction, and frequent, but not severe episodes of pain not to be clinically differentiated from angina. Both had cholelithiasis, and both were completely relieved of pain following removal of the gall bladder. One died a year after operation during a second major infarction, and the other was living three years after the operation and was still free of pain.

Finally I would like to say a word about the electrocardiogram in these patients. All too often a patient tells me that his doctor has said he could do this or that, if the electrocardiogram has become "all right." Following an acute infarction the electrocardiogram may again become quite normal. On the other hand it may remain grossly abnormal indefinitely and yet the patient may be doing quite well. I think it is probably true that the greater the damage, the more apt the electrocardiogram is to remain abnormal. Nevertheless, we can not determine the functional capacity of a heart by the pattern of its electrical activity; your other observations of the patient are of more value in assessing his physical capacity than is the electrocardiogram. However, it is probably wise to recheck the electrocardiogram from time to time for significant changes that may occur without co-existing clinical symptoms. The converse of this statement is also true—significant alterations in symptomatology may occur without accompanying electrocardiographic changes. It is just as important to note that a patient who could walk ten blocks without angina, suddenly, is able to walk only two. Very probably there has been further occlusion and a period of rest may enable the collateral circulation to take over the additional burden, whereas maintenance of customary activity might end in further infarction. The sudden onset of angina where it has not previously existed also should lead one to think of further occlusion and should be treated by rest and other appropriate measures. Here, perhaps, treatment with anticoagulants might prevent the thrombosis that may follow a sudden increase in the degree of occlusion. The period of rest, however, need not be more than ten days to two weeks unless infarction does take place. Other symptoms such as paroxysmal dyspnoea or a sudden diminution in exercise tolerance should be evaluated in a similar fashion. Let me say at this point that I do not do stress tests where the electrocardiogram is already abnormal, or immediately after a distinct change in the patient's symptoms.

In concluding this discussion, I would reiterate what I said in its beginning—your objective in the handling of a patient who has had myocardial infarction should be to return him to as near a normal life as is consistent with a reasonable degree of safety. The term normal life certainly does not include activities that are unwise for anyone in the patient's age group. Your clinical judgment in assessing a patient's physical capacity cannot be superseded by the use of "gadgets." Remember also that emotional stresses and strains can play an important role in the symptomatology of your patient, perhaps especially in regard to the frequency of anginal episodes.

THE TREATMENT OF PULMONARY ABSCESS*

R ADAMS COWLEY, M.D.†

The purpose of this paper is not to discuss the etiology or pathology of lung abscess, nor which antibiotics to use for the specific type of organism encountered. It is instead an outline of treatment of lung abscess, once the diagnosis has been made.

Pulmonary abscess is not a medical problem nor is it a surgical problem, but a combination of both. It is an unpredictable disease with ever present surgical possibilities, and the best results are obtained by a physician and a thoracic surgeon working as a close team. Most clinicians believe that pulmonary abscess is a disease of aspiration rather than embolism. It has the characteristics of an abscess anywhere in the body, in that cure is dependent on adequate drainage.

I am opposed to treating a lung abscess medically for one period of time and surgically for another. If the abscess is to be treated successfully, it should be treated during the acute phase by an integrated team. Within six weeks from onset, the optimum time for curative measures has passed and chronic pathological changes have already become established in the pulmonary parenchyma.

Once the patient with pulmonary abscess has come under your care, improvement must be prompt and progressive or the course of treatment should be radically changed. The improvement must be both clinical and roentgenological. No abscess is doing well which remains unchanged for two to three weeks at a time on the X-Ray film, even if there has been an amelioration of symptoms. Since all pulmonary abscesses communicate with bronchi, it is possible that internal or bronchial drainage will suffice. With this in mind, it becomes apparent that an appreciable percentage of abscesses may be cured by utilization of such drainage. This internal type of drainage is promoted by postural drainage and bronchoscopic aspiration. Poor postural drainage alone may produce more harm than good. Certainly an abscess in the upper lobe is not improved by postural drainage with the head placed in a dependent position. Many persons are acutely ill and cannot stand the physical exertion of routine postural drainage, and it must therefore be individualized.

---

* Presented at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, Wednesday Morning, April 29, 1953, Osler Hall, Baltimore, Maryland, under the title, "Medical and Surgical Treatment of Lung Abscess."

† From the Department of Thoracic Surgery, University of Maryland School of Medicine.

The position which makes the patient cough the most and which utilizes the force of gravity should be assumed. This position, once decided on, should be used five to six times a day for a period of five minutes and should be personally demonstrated by the physician. At night, moderate Trendelenberg position will further increase gravitation of sputum to the trachea for evacuation and does not interfere with sleep. Another adjunct which complements postural drainage is the daily installation of endotracheal penicillin solution or other antibiotics. Their local application to a draining bronchus is efficacious. This procedure is carried out each morning before breakfast. It is easily accomplished by abolishing the gag reflex with a ½% pontocaine spray, and instilling 3 cc. of the penicillin solution (40,000 units per cc.). The patient is then postured so that the solution reaches the involved segmental bronchus.

It is obvious to those experienced in bronchoscopy that it is a valuable means of improving internal drainage. In the past, bronchoscopy has been used too infrequently during the acute stage. It should be one of the earliest therapeutic procedures employed. It has been stated that many of these patients are too ill to be subjected to bronchoscopy. It should be stated that they are too ill not to be bronchoscoped.

There are many who are not convinced of the value of bronchoscopy in pulmonary abscess. I am sure that such physicians have not had the benefit of an efficiently performed bronchoscopy or they have been swayed by the bronchoscopists enthusiasm and allowed repeated bronchoscopies to be performed without improvement in the patient's condition.

The bronchoscope is not an infallible instrument but it does have a rational use and will perform the following tasks: It helps establish a diagnosis by ruling out neoplasm or by finding an unsuspected foreign body. It will remove obstructing excretions from the main and secondary bronchi, and will shrink the congested edematous mucosa which in itself can cause obstruction. By the use of long curved aspirators, the smaller bronchi of the diseased pulmonary segment and on occasion, the abscess cavity itself can be drained. Direct instillation of antibiotics near the involved bronchial segment can be performed.

In favorable cases, the effect of bronchoscopy can be seen within a few days after the first aspiration. If doubt exists as to further improvement, a second or third bronchoscopy at three to five day intervals is indicated. If there is then still question it is unlikely that improvement has occurred and the treatment should be changed.

Evidence of clinical improvement is a decrease in cough, a reduction in sputum and fever, a change in odor and character of the sputum, and a feeling of well being. Should fever continue unabated and the secretions remain purulent and foul, it is certain that bronchoscopy is not effective.

Contra-indications for bronchoscopy are few. Brisk hemorrhage is a contra-indication, as is sudden chest pain with dyspnea, as this is evidence of rupture of the abscess into the pleural cavity. The former is an indication for surgical intervention; the latter, because of its overwhelming toxicity, resulting from insult to the pleura, needs rapid surgical evacuation—truly a surgical emergency.

If, within two to three weeks, and at most six weeks from the time of onset, there is no evidence of steady improvement, external surgical drainage should be undertaken.

If performed within this period of time, it is improbable that changes in the lung parenchyma and bronchial damage has occurred.

It has been demonstrated that most abscesses can be drained by a "one stage" technique, with a mortality rate of less than 4% in the acute stage. Since nearly all abscesses present on a pleural surface, adhesions rapidly form between the lung and thoracic wall. Accurate roentgen localization is thus necessary. If after resection of one or two ribs, pleural symphysis is not observed, some type of irritating pack is used and the incision closed, to be opened two to seven days later when adhesions are suspected. At the time of open drainage, a biopsy specimen of the abscess wall is removed for pathological study. In certain cases, this may prove tuberculosis or other granulomatous disease, when all other tests are consistently negative.

The treatment of chronic pulmonary abscess presents a considerably different problem. External drainage is often unsuccessful because of secondary changes in the lung. If drainage has been established, often the cavity does not close and fistulae remain open.

A complete study of the lung therefore should comprise an adequate number of roentgen films taken in different positions and also should include fluoroscopy, bronchoscopic examination and bronchography.

If bronchial involvement is demonstrated, then some type of pulmonary resection is the treatment of choice. Lobectomy performed in the modern manner carries far less hazard than external drainage of a chronic abscess. In general, the more chronic the abscess, the less chance it has of being cured by external drainage.

What is meant by "chronic lung abscess"? This is an abscess which shows evidence of secondary changes in the bronchi or surrounding lung parenchyma as evidenced by fibrosis, atelectasis, bronchiectasis, stenosis, and often daughter abscesses, involving one or more lobes or even a whole lung and is entirely unrelated to the age or time of onset. Such an abscess, depending on its extent is best treated by primary segmental resection, lobectomy, or by pneumonectomy. Indications for resection other than the above mentioned complications of lung abscess is profuse hemorrhage, or when the diagnosis of malignancy is entertained. For obvious reasons, it is better to primarily resect abscesses in children. Abscesses which do not present themselves for external drainage, such as on the diaphragmatic surface, mediastinum or other inaccessible places, are again best treated by primary resection.

In summary, patients who do not improve progressively on a regimen consisting of postural drainage, bronchoscopy, and the antibiotics should be subjected to surgical drainage within a relatively short period of time (usually from 3 to 4 weeks). This means that ideally surgery will be performed in the acute or subacute stage. It must be kept in mind that holding ones own is not sufficient. A stationery course here is a retrogressive course. Chronic lung abscess is best treated by primary resection. I believe this will eventually replace open drainage in all forms of lung abscess except those where the disease is fulminating and drainage becomes a life saving procedure.

THE PHARMACEUTICAL ASPECTS OF PRESCRIPTION WRITING*

NOEL E. FOSS, PH.D.†

We of the Maryland Pharmaceutical Association are very pleased to have this opportunity to meet with the members of the Medical and Chirurgical Faculty of the State of Maryland. We are both members of the public health team which has for its primary purpose improving and maintaining the health of the public.

---

* Presented at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, Wednesday Morning, April 29, 1953, Osler Hall, Baltimore, Maryland.

† Dean of the University of Maryland School of Pharmacy.

Although there are many problems common to both of us which could be discussed today, I have chosen to discuss with you the pharmaceutical aspects of prescription writing.

A prescription is a written order of the physician for a remedy or medicine for a particular patient usually accompanied with directions for its administration to the patient. It is designed to procure for the patient a special remedy suited to his particular purpose and in such quantity as the physician deems needful.

Prescriptions should always be written carefully and legibly. Cases of damage suits against pharmacists have resulted from mistakes in deciphering what the physician had in mind. Usually the pharmacist calls the physician when there is any question as to the nature of the remedy or the directions, but this procedure consumes valuable time both for the pharmacist and the busy physician. Frequently a prescription that should be delivered immediately is delayed while the pharmacist locates the physician to clarify what was intended.

More recently the physician-pharmacist-patient relationship has been affected by the Durham-Humphrey amendment to the Federal Food, Drug and Cosmetic Act. This amendment, with which most of you are familiar, provides a statutory definition of certain types of drugs that may be sold by the pharmacist only on the written prescription of a "practitioner licensed by law to administer such drugs." It further provides that prescriptions for these drugs cannot be refilled except on the authorization of the prescribing physician. The prescription or refill authorization may be either written or oral (telephone). In the latter case the pharmacist is required to make a written record of the oral renewal and file it.

It must be further kept in mind that the definition in the law for prescription drugs includes drugs besides those that are directly dangerous. The three categories defined in the amendment are:

(1) Certain hypnotic or habit-forming drugs specifically named by the law, and their derivatives.

(2) A drug that is not safe for lay use "because of its toxicity or other potentiality for harmful effect, or the method of its use, or the collateral measures necessary for its use."

(3) A "new drug" that has not been shown to be safe for indiscriminate use.

Prescription drugs as defined above must be labelled by the distributor with the legend: "Caution: Federal law prohibits dispensing without prescription." If the label for a drug with this caution includes any directions for dosage or for use, it is designed primarily for the enlightenment of the pharmacist as well as the physician. On the other hand, any drug whose label includes the caution legend is a direct notice to the pharmacist, as well as the physician, that the product or preparation cannot be sold without a prescription.

Although there has been little difficulty insofar as original prescriptions are concerned, confusion has arisen over the requirement that refills must be authorized by the prescriber. A great deal of annoyance and misunderstanding can be avoided and compliance with the law facilitated if the physician at the time of writing or telephoning the original prescription would include instructions about refilling. The physician can authorize as many refills as he desires or he can authorize refilling for as long a time as his professional judgment indicates before he sees his patient again. Likewise, the physician can conserve his time by specifying that the prescription shall not be refilled. This informs the pharmacist that the physician wishes to see the patient before the prescription is refilled and hence saves much valuable time in phone calls for both the pharmacist and the physician. Most prescription blanks now include printed designations which permit the physician to indicate the number of times the prescription may be refilled, or that it should not be refilled.

It might be well to add a brief comment about the use of refill instructions such as "ad lib," "as requested," or "PRN." The Food and Drug Administration has investigated cases in which prescriptions for hypnotics, such as the barbiturates, or central nervous system stimulants, such as the amphetamines, were being refilled many years after they were written and which, in effect, permitted their use on a daily basis. It is quite obvious that the drugs in these cases were not being supplied in accordance with the will and purpose of the physician who wrote the original prescription. If the refill instruction is of an indefinite and continuing type referred to above, correction of abuses is complicated and difficult. It has been suggested that pharmacists should exercise their professional judgment and check with the physician when there is any indication that this refill privilege is being abused. I am sure you will agree that the alert physician will welcome such interest by the alert pharmacist.

On the other hand, it will be necessary for the pharmacist to check with the physician when a patient presents for refilling an old prescription which calls for a present day "legend drug." We trust that you will be tolerant in this matter of calls since it is the duty of the pharmacist to obtain the approval of the physician before refilling such a prescription.

We might emphasize that the pharmacist has a responsibility under the law to accept an order for a prescription drug only if it comes from "a practitioner licensed by law." We recognize as a practical matter that the physician's office nurse or secretary will, in many cases, telephone prescriptions or even authorize refills at your instructions, but it is the pharmacist's responsibility to make certain that the order is bona fide. Of course, nothing in the Food, Drug and Cosmetic Act in any way modifies the law and regulations relating to prescriptions for narcotics.

Although it is sometimes easier for the busy physician to tell the patient what to get, it is strongly recommended for two reasons that he write a prescription for the specific medication or remedy. First, the patient may confuse the name, especially in this age of euphonious trade names, or forget the name completely. Some years ago a patient requested Argyrol Solution when the doctor actually intended him to obtain Agarol. Second, the patient often consults the pharmacist to learn if the product that the doctor told him to obtain is suited to his needs without disclosing that the medication was recommended by a physician. On the other hand, a pharmacist considers a doctor's prescription as a private communication and always refers the patient to the doctor for any information relative to the action of the drug.

Closely allied to the verbal ordering of drugs for the patient is the practice of handing out samples indiscriminately. This is bad for the patient and bad for the doctor. It sends the patient down the road to self-medication, at the same time lessening the doctor's control of the patient. Frequently the patient passes the name of the item on to his friends; his friends do likewise; and in a surprisingly short time a new drug product becomes a household word.

With the passage of the Durham-Humphrey Amendment, there is another factor which enters into the practice of handing out samples if they are "legend drugs." Very often the patient takes the sample to his pharmacist and asks for another supply of this particular drug. When the pharmacist informs him that he cannot sell the drug without a physician's prescription, the patient immediately wants to know why. The pharmacist generally replies that it is a dangerous drug and immediately the patient becomes alarmed. It is, therefore, always good practice for the physician to write the prescription for the drug or drugs which he intends the patient to have.

One word about drugs intended for investigational use only. It is strongly recommended that the physician caution the patient using the drug that the drug can be obtained only from him or from the hospital with which he is associated and in no case will it be available from a pharmacist. Sometimes patients, probably unknowingly to the doctor, request preparations of this type from the pharmacist and the pharmacist spends considerable time attempting to locate the drug or preparation without realizing that it has not yet been released for prescription use. There are so many new preparations on the market today it is almost impossible for the pharmacist to be aware of all the new ones that are released for prescription use.

In spite of the fact that the pharmacist is also a business man, I do wish to point out that because of his professional knowledge he has the right to expect the confidence and respect of his medical colleagues. He has been trained for four years in a college in one of the medical specialties. In addition, he has obtained the benefits of a one year apprenticeship or internship. He has been taught drugs from the chemical, physical, microscopic, pharmaceutical, pharmacognostic, physiological, pharmacological and bacteriological points of view. He has pursued a standard professional course to fit him for the job of preparing and dispensing medicine. He is the one member of the public health team who may claim to be an expert in pharmaceutical practice.

It is rather interesting to note that the Maryland College of Pharmacy, the predecessor of the University of Maryland School of Pharmacy, was organized in 1841 by a group of physicians and pharmacists. Three of the physicians, Doctors Samuel G. Baker, W. E. A. Aikin, and Wm. Riley, represented the Medical and Chirurgical Faculty. Although the course in the Maryland College of Pharmacy consisted only of lectures the first few years, it is interesting to note that from April 1844 the Maryland College of Pharmacy entered into an arrangement with the Faculty of Physic of the University of Maryland whereby the lectures of the college of pharmacy were united with those of the University so as to enable the students in medicine to have the benefits of the lectures on pharmacy in return for which the students of pharmacy were to enjoy the privilege of attending the lectures in chemistry by Professor W. E. A. Aikin, Dean of the Faculty of Physic. The lectures on pharmacy were to be delivered in the University building at Lombard and Green Streets, where quarters were placed at the disposal of the college of pharmacy. I mention this historical data to show the close relationship which has existed between the medical and pharmaceutical professions in the State of Maryland for one hundred and twelve years. Students in the School of Pharmacy at the University of Maryland are now again taking courses in physiology and biochemistry from these respective departments in the School of Medicine so that we once more have a close relationship.

We trust that the Maryland Pharmaceutical Association and the Medical and Chirurgical Faculty will work more closely together in the future to the benefit of both of these health professions. We need to cultivate a spirit of mutual understanding and cooperation if we are going to accomplish our best for the health of the public.

CURRENT VIEWS ON POLIOMYELITIS*

DAVID BODIAN, M.D.†

The floodlights of publicity not only have their proper function of revealing activity and progress in a field of public interest, but, as we all know, often produce the undesirable side-effects of magnification and distortion. The encouraging activities and progress in immunization against poliomyelitis are particularly vulnerable to these side-effects, because of the special incentive for wishful thinking which is associated with this disease, both in lay and in medical circles. It seemed to me, therefore, that it might be timely to present some of the current views on poliomyelitis which might serve as a background for your own evaluation of the status and prospects for passive and active immunization in poliomyelitis, and of the reservations to be kept in mind.

---

* Presented at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, Wednesday Afternoon, April 29, 1953, Osler Hall, Baltimore, Maryland.

† Associate Professor of Epidemiology, The Johns Hopkins University School of Hygiene and Public Health. Aided by a grant from The National Foundation for Infantile Paralysis, Inc.

The progress which has been made in research on immunization has been accompanied by new findings in the field of pathogenesis of this disease. These have reoriented the thinking of many workers in regard to the nature of the infection. The advances have also, in a remarkable way, offered both increased hope for the development of an effective vaccine, and essential tools for this purpose. The finding that poliomyelitis virus can be grown in tissue cultures in the absence of nervous tissue has presented us with two important tools, the first being the means for producing large amounts of virus easily and cheaply. Second, it has made possible a superior method for measuring the concentration of virus in fluids from which vaccine is prepared, or the concentration of antibody in the serum of immunized individuals, whether experimental animals or human beings.

The tissue culture developments have also had the effect of reopening the question of whether the virus is confined only to nervous tissue in the infected person, or whether it also may multiply in non-nervous tissues, in which it may conceivably be more susceptible to neutralization by antibodies. As a matter of fact, evidence regarding the places in the body where virus multiplies is still incomplete. There is general agreement that virus first multiplies in the alimentary tract, and later invades the central nervous system. It is still not clear whether in its passage from the alimentary tract to the central nervous system, the virus may multiply in other structures, such as lymph nodes or spleen, or whether it passes along nerve fibers in an insulated fashion. There is now conclusive evidence, however, that virus is present in the blood serum in the pre-symptomatic period of the disease in human beings as well as in experimental animals. This, and other evidence, has suggested a very important possibility, namely that virus may invade the nervous system by way of the blood stream rather than by way of nerve fibers from the alimentary tract, as was previously believed by most of us. Although conclusive evidence for this view is not yet available, nor for the view that the virus is restricted to nervous tissue from its moment of penetration into the infected individual, the implications for our understanding of the mechanisms of infection and of immunity are so important that much effort is being directed at obtaining a conclusive solution to this problem.

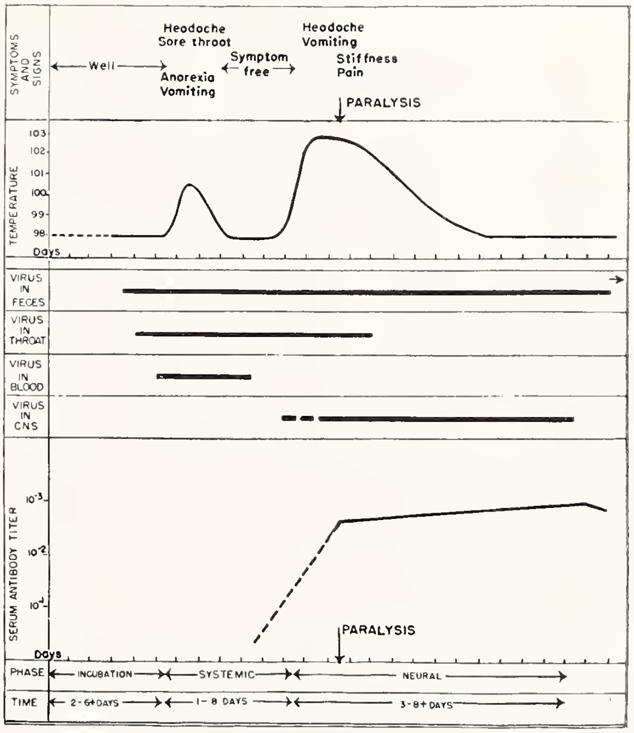


Chart 1

Chart 1 summarizes the evidence available regarding the time course of isolation of virus from important sites in the body, of development of serum antibody during an infection, and of occurrence of clinical signs and symptoms.‡ Of particular importance in current thinking is the fact that conclusive evidence indicates that the presence of specific serum antibody, before exposure, is an accurate indicator of immunity against paralytic infection. However, as shown in the Chart, in the natural paralytic disease serum antibody is already formed by the time of onset of CNS signs, presumably as a result of earlier virus multiplication outside the CNS. Despite this early antibody formation, the infection in the CNS may progress to produce severe paralysis or death. Three important conclusions emerge from these facts. First, in the natural paralytic infection the virus must localize in the nervous system before the formation of serum antibody reaches a high enough level to neutralize it. Second, by the time of onset of clearly recognizable symptoms of poliomyelitis it is too late to administer antibody in the form of gamma globulin or otherwise. The patient has already made more antibody than we can administer artifically. Third, prevention of paralysis by means of immunization should be possible if even low levels of serum antibody are produced, providing this is done before onset of typical symptoms and preferably before exposure. In other words, a small amount of antibody may be effective before exposure, but large amounts are ineffective after onset of CNS symptoms.

---

‡ More extended discussions of these points will be found in (1) and (2), which also contain more detailed bibliographic references.

CHART 2

Limitations of Passive Prophylactic Immunization
(Gamma Globulin)

1. Transient duration of any possible protection (few weeks).
2. Protection not certain.
3. Ignorance of optimal time of injection, because of ignorance of
   a. Who is susceptible
   b. Time of exposure
4. Limited supply and great expense of gamma globulin.
5. Large doses necessary, and repeated doses may hypersensitize.
6. Possibly inadequate potency, risk of reactions, and unknown risk of infectious hepatitis, in small and untested commercial lots prepared with new methods.
7. Danger of accidental intravenous injection.
8. Low incidence, even during epidemics, means that thousands may have to be injected to prevent a single paralytic case.

CHART 3

Problems of Active Prophylactic Immunization
(Killed Virus Vaccine)

1. Duration and degree of protection against *paralytic infection* not yet tested in human beings.
2. Reactions in large scale use not known.
3. Only a few virus strains and inactivating agents tested thus far.
4. Methods for standardizing potency of batches of vaccine not developed.

The two major steps being explored are first, passive prophylactic immunization with gamma globulin, and second, active immunization with vaccines prepared from formalin-treated virus. Such so-called "killed" virus vaccines are rendered non-infective while still retaining antigenic potency for active immunization purposes.

Although there is limited evidence that passive immunization with gamma globulin may prevent paralytic cases under certain conditions, even Hammon and his colleagues,[3] who carried out the field trials, point out the severe limitations of this method. Chart 2 lists these drawbacks, which suggest that indiscriminate use of gamma globulin may not only be very wasteful, but may even be hazardous.

On the other hand, although the hope exists that vaccines will be developed before long which will not possess the limitations of gamma globulin, at the present time it should be clear that much work is needed to make possible the large-scale production of safe vaccines of standard potency, and to evaluate their efficacy in children over an adequate period of potential exposure. Chart 3 lists some of the problems which still remain to be solved. Nobody can as yet say how much more experimental work and how many small-scale human trials of new vaccines will have to be undertaken before we can be certain that all of the major problems are resolved.

There are a number of ways in which vaccines can be prepared, and many virus strains which are available for use in vaccines. It is important that time be allowed to develop a vaccine of almost absolute safety and proven potency before wide-spread use begins. In the meantime, it is equally important to appreciate the limitations of gamma globulin as an immunizing agent, so as to minimize the wastefulness and even dangers of its irresponsible use. The practicing physician, who will be entrusted with the responsibility of administering the new immunizing materials, is in the best position to resist the abuses which may arise from the pressures of overly impatient or even hysterical parents.

BIBLIOGRAPHY

1. Bodian, D., A reconsideration of the pathogenesis of poliomyelitis. Am. J. Hyg., 1952, **55:** 414–438.
2. Bodian, D., Pathogenesis and immunity in poliomyelitis. Pediatric Clinics of North America, 1953, **1:** 5–11.
3. Hammon, W. McD., Coriell, L. L. and Wehrle, P. F., Evaluation of Red Cross gamma globulin as a prophylactic agent for poliomyelitis. 4. Final report of results based on clinical diagnosis. J. A. M. A., 1953, **151:** 1272–1285.

THE DIONE DRUGS IN PETIT MAL SEIZURES*

RUTH W. BALDWIN, M.D.†

This paper is being presented primarily to show, by means of electroencephalograms repeated at intervals, how some patients with petit mal seizures improve dramatically on treatment with the dione drugs, principally tridione. The presence of petit mal seizures is demonstrated in the electroencephalograms by the spike slow wave complex. Secondarily, the paper shows the importance of an electroencephalogram prior to treatment of any patient giving evidence of having epilepsy.

First a brief discussion of epilepsy of the petit mal or triad type as proposed by Lennox[1] is necessary in order that there might be a clearer understanding of petit mal. It cannot be emphasized too strongly that it is not a small or mild convulsion.

There are 4 kinds of epilepsy recognized today as shown in Figure 1. First, we see convulsions including Jacksonian March, focal, grand mal and tonic seizures. The last are usually seen in the young child only, and these change into the grand mal as the individual becomes older, if not controlled by medication in childhood. Secondly, we have the petit mal triad including petit mal absence or staring seizures which are brief lapses of consciousness, akinetic seizures or sudden loss of postural control, and the myoclonic jerk either single or massive which is a sudden, quick contraction of the muscles. Each of the patterns in this group will be discussed in more detail. Thirdly, there are the psychomotor or psychic equivalents—periods of amnesia. Last, we find the diencephalic or autonomic seizures which are paroxysmal disorders of the central nervous system.

Though the seizures of the petit mal triad are vastly different, they have many characteristics in common: namely, short duration, less than a minute; frequency, as many as 100 or more a day; sudden onset and termination; disappearance as patient reaches puberty; electroencephalographic similarity of spike slow wave complexes; improvement with same medication.

Petit mal absence or staring seizures are usually seen in the child of school age, where frequently the only complaint is from the teacher that the child pays no attention and daydreams. In these seizures the child stops his activity, stares straight ahead, turning his eyes to one side or the other or rolling them back with or without blinking of the lids. He may move his hands or feet in a rhythmic pattern with all movements at the rate of about 3 per second. Occasionally there is incontinence of the bladder in the more severe of these seizures. They last only a few seconds, not more than 45, and may occur 100 or more times a day, with the child returning to his activity at the end of each usually not realizing he has had a seizure.

---

* Presented at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, Wednesday Afternoon, April 29, 1953, Osler Hall, Baltimore, Maryland.

† Director of Seizure Unit, Department of Pediatrics, University of Maryland School of Medicine, Baltimore, Md.

The akinetic seizures are characterized by a sudden loss of postural control, such as a sudden nod of the head or fall to the floor, collapsing in a heap. These are usually first noted by the mother when she is feeding the young infant in the highchair and notices that his head falls forward frequently or when he is learning to walk and after a few steps crumbles to the floor in a heap straightening up in a few seconds. These may occur many times a day, and they frequently occur in bouts.

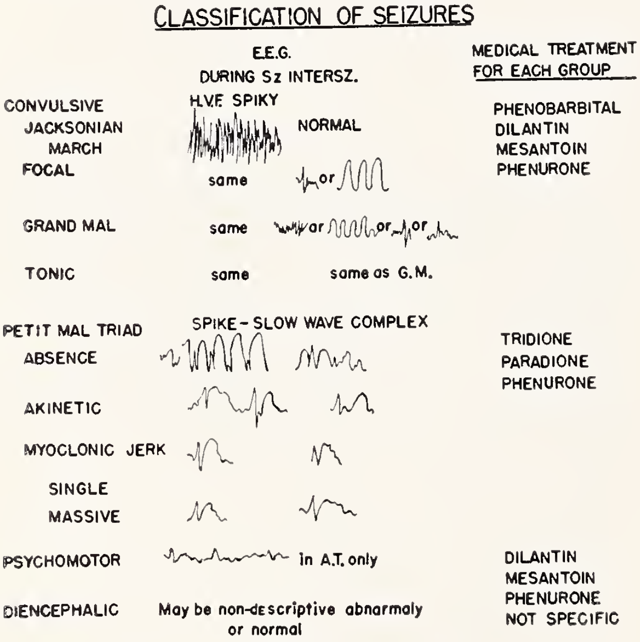

CLASSIFICATION OF SEIZURES
E.E.G.
DURING Sz INTERSZ.
MEDICAL TREATMENT FOR EACH GROUP
CONVULSIVE
JACKSONIAN MARCH
FOCAL
H.V.F. SPIKY
NORMAL
same
or
PHENOBARBITAL
DILANTIN
MESANTOIN
PHENURONE
GRAND MAL
same
or
or
or
TONIC
same
same as G.M.
PETIT MAL TRIAD
SPIKE-SLOW WAVE COMPLEX
ABSENCE
TRIDIONE
PARADIONE
PHENURONE
AKINETIC
MYOCLONIC JERK
SINGLE
MASSIVE
PSYCHOMOTOR
in A.T. only
DILANTIN
MESANTOIN
PHENURONE
NOT SPECIFIC
DIENCEPHALIC
May be non-descriptive abnormaly or normal

Fig. 1

The single myoclonic jerk is a sudden jerk or a single contraction of the flexor muscles of the arm, leg or head. Anything held during one of these seizures of the arm is dropped or thrust away. The massive jerk is a sudden contraction of all the flexor muscles of the body, causing loss of posture. These are frequently mistaken for mild grand mal seizures, as the patient becomes momentarily stiff, may bite his tongue or injure himself; but no sleep or dazed period follows. Atypical seizures are seen at times, and included in this small group is a clinical grand mal case showing a spike slow wave in the electroencephalogram.

Many drugs such as phenobarbital, mebaral, dilantin, mesantoin, benzedrine, dexedrine, glutanic acid and caffeine have been used for these seizures, giving benefit to only a relatively few patients. Ketogenic diets and acidosis have also been of benefit to only a few. In 1944 a drug called tridione was first used experimentally by several investigators[1-6] and it was found to be very dramatic in its effect on petit mal seizures, but it seemed to accentuate grand mal seizures.

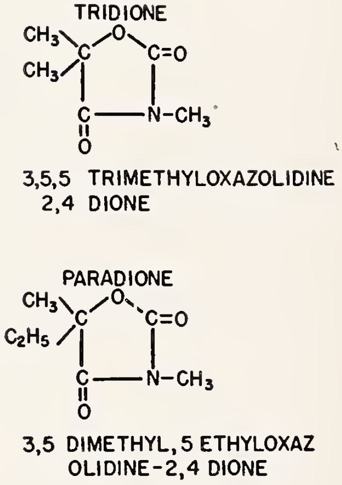

TRIDIONE
3,5,5 TRIMETHYLOXAZOLIDINE 2,4 DIONE
PARADIONE
3,5 DIMETHYL, 5 ETHYLOXAZOLIDINE-2,4 DIONE

Fig. 2

Tridione is a trimethyloxazolidine dione shown in Figure 2. Its analogue, paradione, dimethylethyloxazolidine dione, was produced because of the toxic reactions of tridione, the most severe of which is aplastic anemia.[7-12] Blood counts at monthly intervals on all patients taking either of these drugs have been found to be sufficient by Davis and Lennox[9] in a large series of cases. The fall in leukocytes was found to be very gradual. A slight increase in the lymphocytes and eosinophiles was also found with no change in the platelet count. Most fatal cases of aplastic anemia reported had not had monthly blood counts. Other toxic manifestations of these drugs are rash, photophobia and drowsiness. The toxic reactions with paradione are usually less severe than with tridione, but its effectiveness has also been found to be less.[13] The dosage of both tridione and paradione is the same, starting with 1 capsule of 0.3 gm. a day in an infant and 3 capsules a day in a child of 6 years or over. They are both increased at monthly intervals by 1 capsule a day until all seizures are controlled or until toxic reactions occur. The top dosage for an infant would be 3 to 4 capsules daily; while in an adolescent child or older individual, it would be 12 to 14 capsules a day.

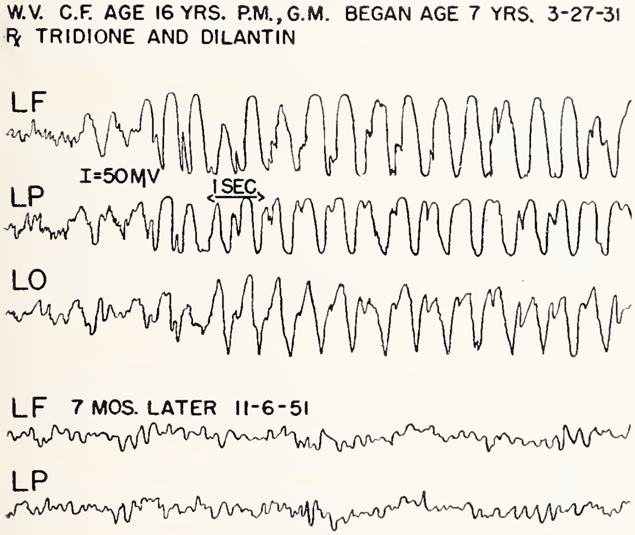


Fig. 3a

No attempt is being made to give a percentage of patients cured or improved with the dione drugs as used in the University Seizure Unit, in this paper. Brief mention can be made of Lennox[3] in his series of 166 patients having some form of petit mal. Of this series, 31% were free of petit mal seizures and 52% were improved, making a total of 83% who were greatly benefited by tridione. Most of these patients had had all other known forms of treatment with little effect.

Figure 3a shows W. V., a colored girl 17 years of age who had had grand mal convulsions since 7 years of age with petit mal staring seizures, 4 to 5 per day, for an unknown length of time as far as could be determined. The first electroencephalogram of 3/27/51 shows the typical spike slow wave complex with 3 such complexes per second and a number of clinical seizures during the record. The patient had previously been on bromides which were discontinued after 2 months and since 8 years of age had taken dilantin, 0.1 gm., three times a day and phenobarbital. At her first visit to the Seizure Unit she was put on tridione, 0.3 gm., three times a day; dilantin was continued and phenobarbital was gradually discontinued. The bottom section of this figure shows her record 6 months later, 11/6/51. Though it is still abnormal, the rate being too slow, there are no petit mal seizure discharges. Monthly blood counts remained within normal limits. From the first day of her new medication the patient had no further seizures, grand mal or petit mal. Figure 3b shows the record of 5/6/52, still abnormally slow; but there are no spike slow waves, though the patient has been off tridione for 3 months; and she has had no seizures of any kind. This patient has not been seen since this date, but recent information indicates she has had no seizures, and she is now taking no medication. Repeated attempts to have her return to Clinic have been unsuccessful.

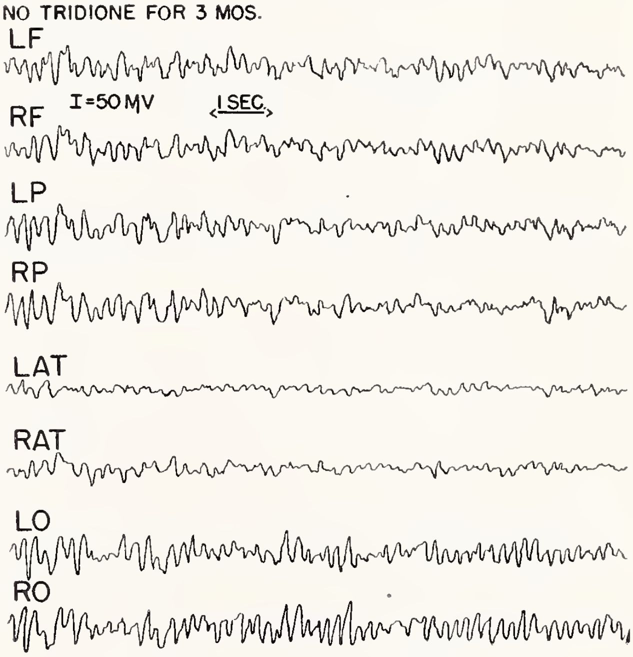


Fig. 3b. Six months later 5/6/52

Figure 4a shows B. M., a white girl of 15 years who had her first seizures of the tonic type as an infant. She was then free until 8 years of age, when she developed petit mal staring seizures; and at 10 years grand mal seizures began to occur. Previous treatments included phenobarbital, dexedrine, cold wave treatments, thiantoin and tridione. At the time of her first visit to the Seizure Unit, 3/14/51, her medication was thiantoin, 0.1 gm., four times a day and tridione, 0.3 gm., 8 capsules per day. The thiantoin was discontinued and dilantin, 0.1 gm., three times a day substituted and the tridione increased to 9 capsules a day. Her electroencephalogram at this time showed the 3 per second spike slow wave complex. From this date she had no grand mal seizures and her last petit mal seizure occurred on 3/23/51. The lower section of this figure giving the electroencephalogram of 8/27/51 shows that there are no petit mal seizure discharges, but the record is abnormal because of the slow and rapid activity. At this time gradual reduction of tridione by 1 capsule monthly was begun; and the electroencephalogram of 3/31/52, Figure 4b, still shows no petit mal seizure discharges. The lower section shows what her record looked like 1 year later, 3/16/53, after she had gone 1 year without tridione medication. The patient is seizure free at the present time. This case illustrates how only an increase of 1 more capsule per day was necessary for successful control.

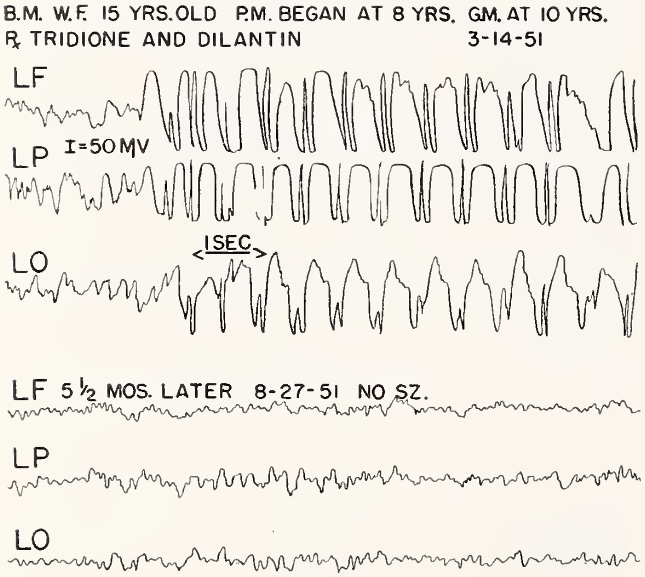

B.M. W.F. 15 YRS. OLD P.M. BEGAN AT 8 YRS. GM. AT 10 YRS.
℞ TRIDIONE AND DILANTIN 3-14-51
LF
LP
I=50MV
LO
1SEC.
LF 5½ MOS. LATER 8-27-51 NO SZ.
LP
LO

Fig. 4a

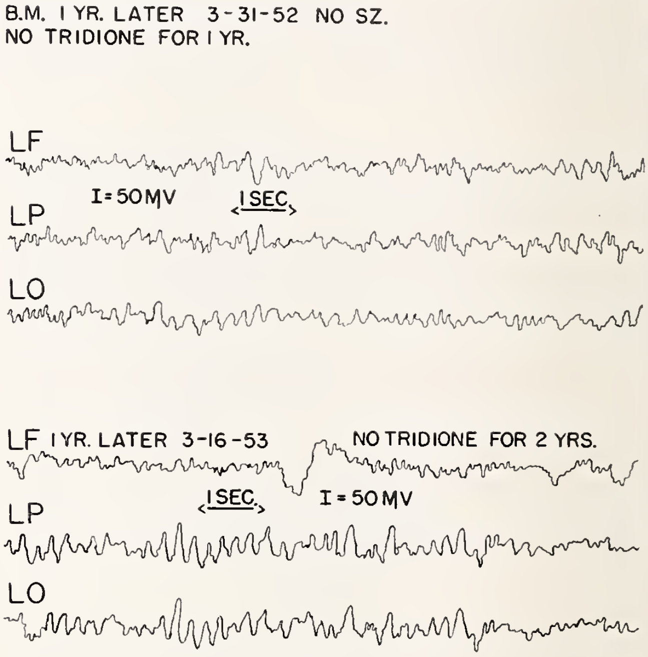


Fig. 4b

Figure 5a shows M. D., a white girl of 17 years who developed her first grand mal seizure at 1 year of age and who since 1947 had been having 1 to 4 of these each year. A neighbor who was along with the family mentioned staring spells that she had noticed that were of no concern to the family. The first electroencephalogram of 2/8/51 showed a 3 per second spike slow wave with several clinical seizures. Since the patient was on phenobarbital for the grand mal seizures, this was continued and tridione, 0.3 gm., three times a day was added for control of the petit mal seizures. However, because of photophobia, the patient reduced the tridione to once daily. Even with this low dosage there was only an occasional petit mal seizure, but the grand mal seizures continued to occur. On 8/28/51 the electroencephalogram of the lower section was obtained and only laval discharges of spike slow wave occurred. The tridione was increased to twice a day and instructions were sent to the family physician to increase the tridione each month until all petit mal seizures were controlled and to have the patient wear dark glasses to counteract the photophobia. The record of 3/4/52 shown in the upper section of Figure 5b is free of all spike slow waves. At this time because of several grand mal seizures, dilantin was added to the medication and the tridione was discontinued. Here we note that the patient was free of petit mal seizures for 2 months only, and the record of 9/16/52 in the lower section of Figure 5b shows that the spike slow wave has returned even though there had been no clinical petit mal seizures during this period of 2 months and no grand mal seizures. Tridione medication was restarted on this patient. The patient has since married and moved out of the state. She has had no further seizures and is expected to return within the next few months for another electroencephalogram. This case shows the inadvisability of discontinuing tridione until a patient has gone at least 6 months free of seizures, even though the electroencephalogram is free of spike slow wave complexes.

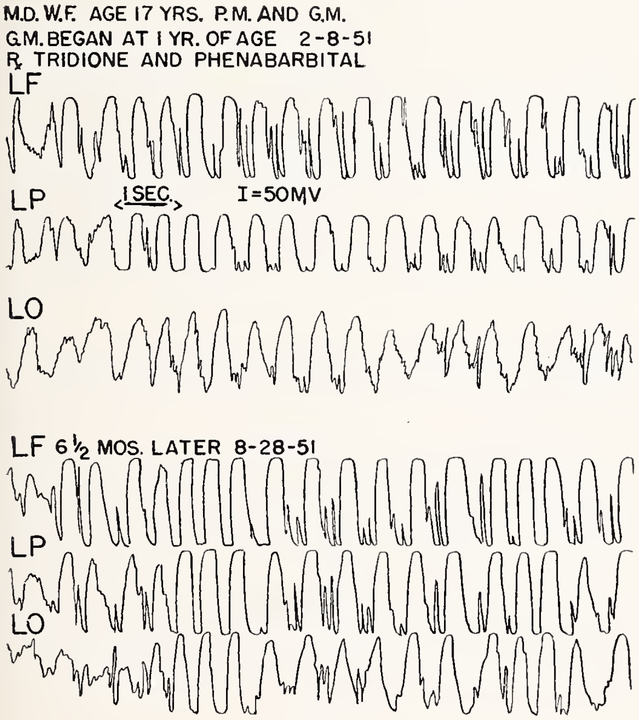

M.D. W.F. AGE 17 YRS. P.M. AND G.M.
G.M. BEGAN AT 1 YR. OF AGE 2-8-51
℞ TRIDIONE AND PHENABARBITAL
LF
LP
1 SEC.
I=50MV
LO
LF 6½ MOS. LATER 8-28-51
LP
LO

Fig. 5a

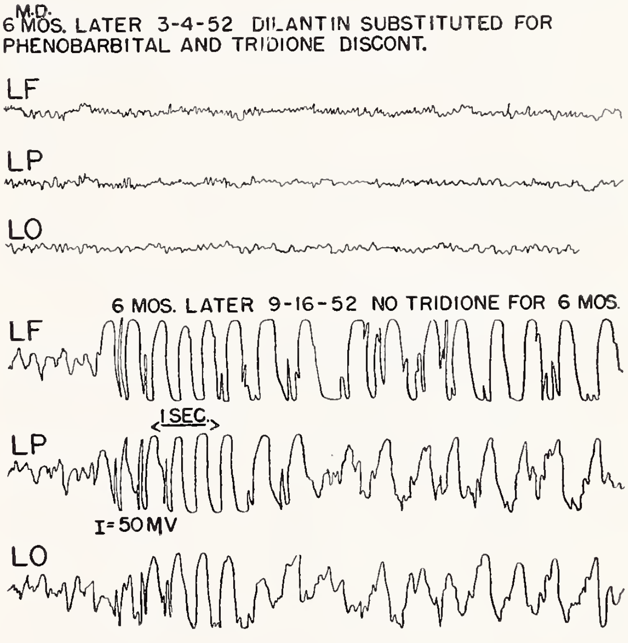

M.D.
6 MOS. LATER 3-4-52 DILANTIN SUBSTITUTED FOR
PHENOBARBITAL AND TRIDIONE DISCONT.
LF
LP
LO
6 MOS. LATER 9-16-52 NO TRIDIONE FOR 6 MOS.
LF
1 SEC.
LP
I=50MV
LO

Fig. 5b

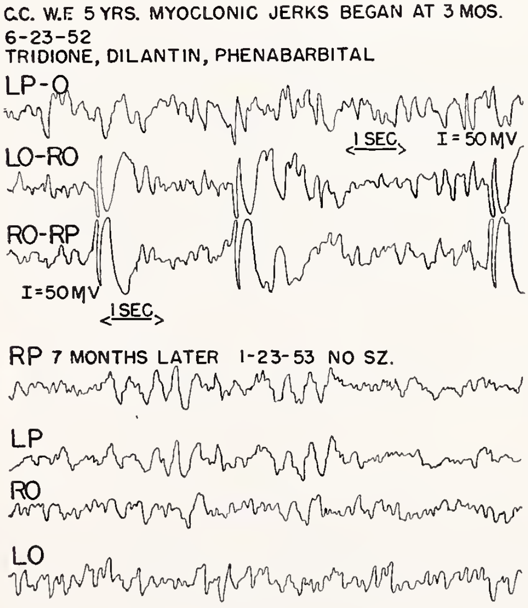

C.C. W.F. 5 YRS. MYOCLONIC JERKS BEGAN AT 3 MOS.
6-23-52
TRIDIONE, DILANTIN, PHENABARBITAL
LP-O
1 SEC.
I = 50 MV
LO-RO
RO-RP
I=50MV
1 SEC.
RP 7 MONTHS LATER 1-23-53 NO SZ.
LP
RO
LO

Fig. 6

Figure 6 illustrates a case of myoclonic jerks in a white girl of 5 years. These occurred in bouts lasting 15 to 20 minutes each throughout a whole day about once each year in the spring with an infection. The child was a breech delivery following a rapid labor of 1½ hours. She was cyanotic at birth, put in oxygen and not expected to survive. The first electroencephalogram of 6/23/52 in the top section of the figure shows a spike slow wave with a right occipital focus. The patient was put on tridione, 0.3 gm., three times a day along with the phenobarbital and dilantin she had been taking. The record of 7 months later in the lower section shows only some slow activity, no spike slow wave. During the month previous to the running of this record the patient's polymorphonuclear cell count dropped to around 2,000 cells, so tridione was stopped. However, it was restarted 2 weeks later, because the count returned to normal. Since the repeat electroencephalogram showed loss of the spike slow wave, the tridione medication was reduced to twice a day. When the polymorphonuclear count dropped again the next month, tridione was discontinued. The count returned again immediately to normal, and the child has had no seizures this spring.

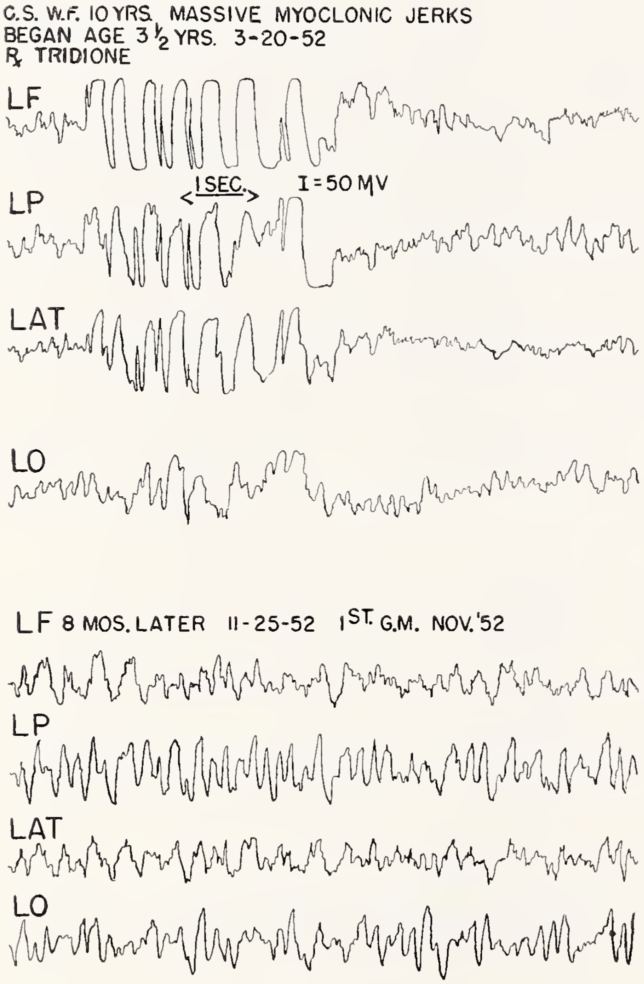

C.S. W.F. 10 YRS. MASSIVE MYOCLONIC JERKS
BEGAN AGE 3 1/2 YRS. 3-20-52
℞ TRIDIONE
LF
1 SEC.
I = 50 MV
LP
LAT
LO
LF 8 MOS. LATER 11-25-52 1ST G.M. NOV.'52
LP
LAT
LO

Fig. 7a

Figure 7a, C. S. is a white girl 10 years old who first starting having convulsions at 3½ years of age. These occurred every 3 to 4 weeks. She was put on phenobarbital and began having very frequent seizures in which the head and arms jerked. These occurred so frequently during a day that it was impossible to keep count of them. Ketogenic diet was tried as well as a phenobarbital derivative, dilantin, mesantoin and several experimental drugs. Her first electroencephalogram done at the Seizure Unit on 3/20/52 showed a spike or a multiple spike slow wave complex in the various areas, occurring sometimes simultaneously in all the leads accompanied by a clinical myoclonic jerk. The patient was started on tridione, 0.3 gm., three times a day, and the experimental medication was discontinued. Her seizures gradually decreased and after 4/21/52, when she started taking 5 capsules of tridione per day, there were no further seizures. In November, 1952, the first grand mal seizure since the child was 6 years of age occurred, and the electroencephalogram of 11/25/52 showed no spike slow wave complexes but slow and fast activity suggestive of a grand mal type of cerebral dysrhythmia. Figure 7b shows the various medications tried before the grand mal seizures were brought under control. First gemonil, a new barbiturate, was added to the reduced dosage of tridione. However, in January, 1953, with her first menstrual period she had 3 grand mal seizures; so the gemonil was gradually discontinued and mysoline, a new English barbiturate not yet on the market, was started in doses of 0.25 gm., three times a day. Since then there have been no seizures of either kind, and the last electroencephalogram of 4/7/53 shows slowing in the right occipital and low parietal areas, some of which appears to be a very immature spike slow wave complex. The next electroencephalogram will be important in indicating whether the spike slow wave has returned or not. So far there have been no petit mal seizures.

The last of the group of myoclonic jerks and grand mal seizures is Figure 8, C. P., a white girl of 2½ years who had her first convulsion with a high fever associated with pharyngitis. The patient was then free of seizures for 3 months and then began having myoclonic jerks, 15 or more a day; and 2 weeks prior to her first visit to the Seizure Unit was very much worse. Her first electroencephalogram of 10/30/52 showed a 2 to 4 per second spike slow wave complex as seen in the upper section of Figure 8. The patient was put on tridione, 0.3 gm., daily. The following day she had a few seizures only and has had none since. Three weeks later this patient was admitted to University Hospital for a tonsillectomy and adenoidectomy, and a repeat electroencephalogram was obtained as shown in the lower section. Here we see a remarkable change in a period of three weeks only, the record now showing a poorly formed spike slow wave in the right anterior temporal area only. This case shows how rapidly the brain wave may begin to return to normal. Tridione medication, however, will not be stopped for at least 6 months and then only if the electroencephalogram is completely normal.

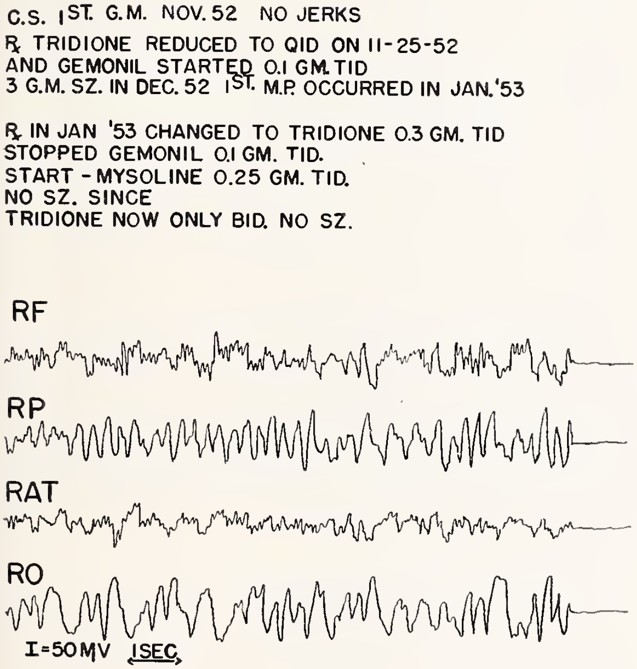

C.S. 1ST G.M. NOV.52 NO JERKS
℞ TRIDIONE REDUCED TO QID ON 11-25-52
AND GEMONIL STARTED 0.1 GM. TID
3 G.M. SZ. IN DEC. 52 1ST M.P. OCCURRED IN JAN.'53
℞ IN JAN '53 CHANGED TO TRIDIONE 0.3 GM. TID
STOPPED GEMONIL 0.1 GM. TID.
START - MYSOLINE 0.25 GM. TID.
NO SZ. SINCE
TRIDIONE NOW ONLY BID. NO SZ.
RF
RP
RAT
RO
I=50MV
1SEC

Fig. 7b

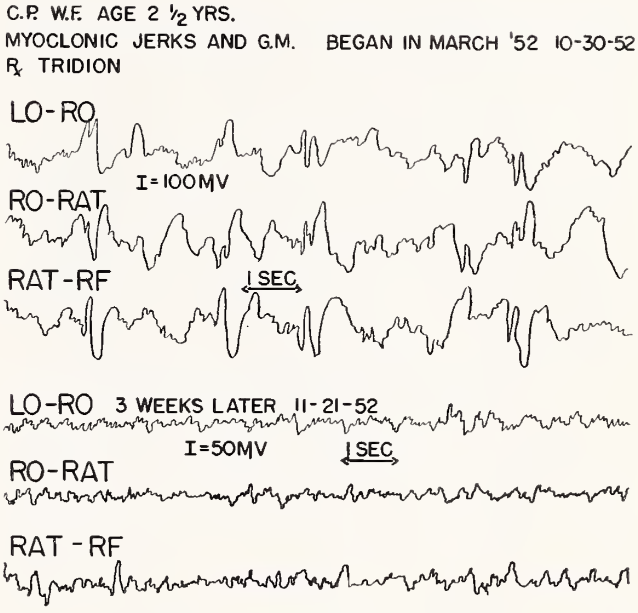

C.P. W.F. AGE 2 ½ YRS.
MYOCLONIC JERKS AND G.M. BEGAN IN MARCH '52 10-30-52
℞ TRIDION
LO-RO
I=100MV
RO-RAT
RAT-RF
1 SEC
LO-RO 3 WEEKS LATER 11-21-52
I=50MV
1 SEC
RO-RAT
RAT-RF

Fig. 8

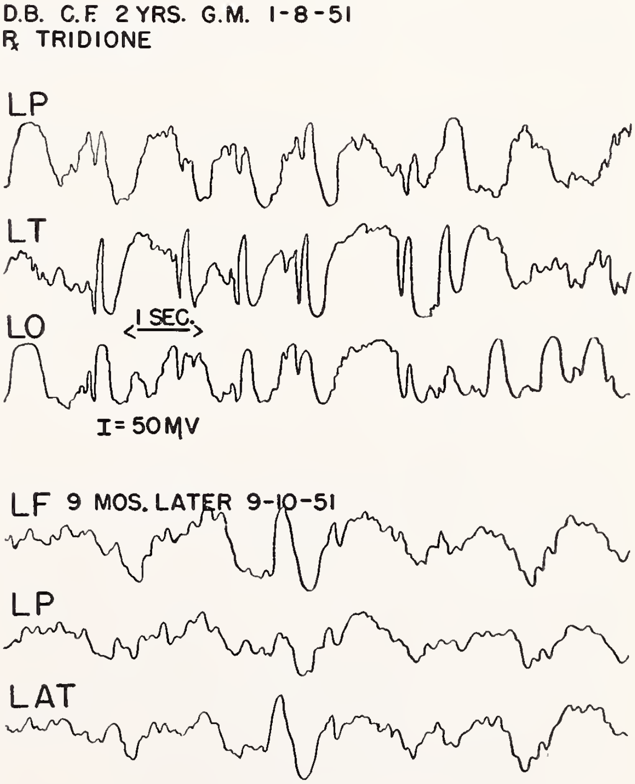

D.B. C.F. 2 YRS. G.M. 1-8-51
℞ TRIDIONE
LP
LT
LO
1 SEC.
I=50MV
LF 9 MOS. LATER 9-10-51
LP
LAT

Fig. 9

Figure 9 shows D. B., a colored girl of 2 years, one of twins. At 3 months of age, she had pneumococcal meningitis with repeated convulsions following. The child had to be readmitted to University Hospital on 2 occasions for convulsions. On the last admission she was comatose for 3 days. Her electroencephalogram at this time, shown in the upper section of Figure 9, shows the 2 to 2½ per second spike slow wave in the frontal areas bilaterally and at times in all the areas. The patient was put on tridione, 0.3 gm., daily. Her seizures stopped; she began to progress in development; and in the next 6 months she developed to a much greater degree than she had in her first 1½ years. She is still mentally back of her twin sister but she is able to talk, walk, memorize nursery rhymes and sing. The record of 9/10/51 in the lower section of the figure shows only a very poorly formed spike slow wave in the left frontal and anterior temporal areas. A more recent electroencephalogram of 2/19/53, not shown here, shows an occasional high voltage slow wave in these areas.

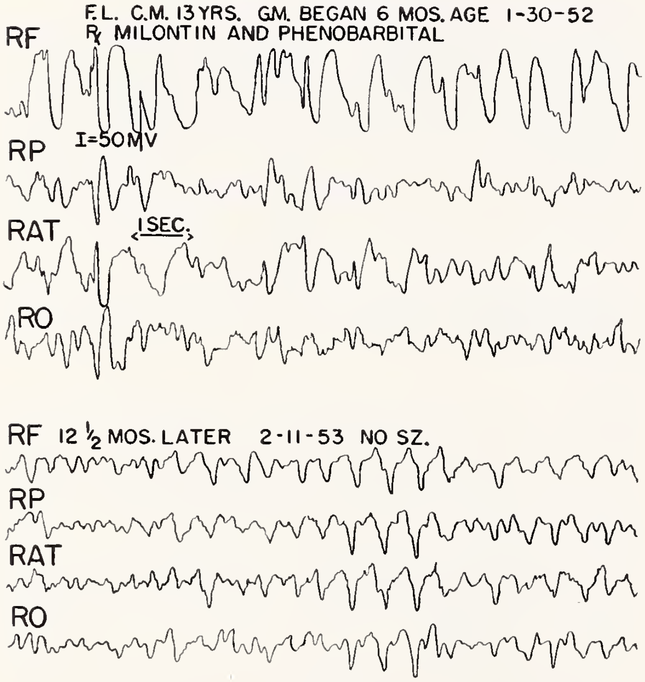

F.L. C.M. 13YRS. GM. BEGAN 6 MOS. AGE 1-30-52
℞ MILONTIN AND PHENOBARBITAL
RF
RP
I=50MV
RAT
1SEC.
RO
RF 12 ½ MOS. LATER 2-11-53 NO SZ.
RP
RAT
RO

Fig. 10

Figure 10 shows F. L. H., a colored boy 14 years old with a history of grand mal seizures having had his first electroencephalogram on 1/30/52. This record showed a 2 per second spike slow wave complex in the right frontal area and during deep breathing in all the areas. The patient was previously on phenobarbital and tridione was added to this. However, the polymorphonuclear count dropped to close to 1,500 cells; and tridione was discontinued. Paradione was started when the count returned to normal. Again the polymorphonuclears dropped, so the patient was put on milontin, a new experimental drug, N-methyl-α-phenylsuccinimide, on 8/28/52. The blood count has remained within normal limits on this drug. The electroencephalogram of 2/11/53 in the lower section shows no spike slow wave complexes. In this case it is difficult to determine which of the 3 medications, tridione, paradione or milontin, was responsible for the change in the electroencephalogram. Since there was a distance of over 100 miles for this boy to travel, it was not feasible to have electroencephalograms done on him between the changes in medication. This case was added last to emphasize the importance of electroencephalograms in the control of patients, because he clinically had grand mal seizures only, but his electroencephalographic record indicated petit mal seizures.

Summary

Petit mal seizures including the staring or absence form, the akinetic and the myoclonic jerks both single and massive, all having spike slow waves in electroencephalograms responding dramatically in a number of cases to the dione drugs, tridione and paradione, have been discussed. The rapid change with loss of the spike slow wave complexes in a period of 3 weeks to 6 months has been shown in the case histories with repeat electroencephalograms. In the last case a spike slow wave was present in the tracing while clinically grand mal seizures only occurred, and with subsequent treatment with tridione, paradione and a new drug, milontin, the record became more normal.

REFERENCES

1. Lennox, W. G., The petit mal epilepsies—their treatment with tridione, J. A. M. A. **129**: 1069–1073, 1945.
2. Perlstein, M. A., and Andelman, M. B., Tridione—its use in convulsive and related disorders, J. Pediat. **29**: 20, July 1946.
3. Lennox, W. G., Tridione in the treatment of epilepsy, J. A. M. A., **134**: 138–143, 1947.
4. Goodman, L. S., Toman, J. E. P., and Swinyard, E. A., The anticonvulsant properties of tridione, Am. J. Med. **1**: 213–228, 1946.
5. Butter, A. J. M., Tridione in the treatment of petit mal, Brit. M. J. **1**: 4539: 13–14, January 3, 1948.
6. Davidoff, E., Clinical and electroencephalographic observations concerning the effect of tridione in epileptic patients, Am. J. Psychiat. **104**: 10: 600–607, April 1948.
7. Harrison, F. H., Johnson, R. D., and Ayer, D., Fatal aplastic anemia following use of tridione and an hydantoin, J. A. M. A. **132**: 1, September 1946.
8. Mackay, R. P., and Gottstein, W. K., Aplastic anemia and agranulocytosis following tridione, J. A. M. A. **132**: 13–16, September 1946.
9. Davis, J. P., and Lennox, W. G., The effect of trimethyloxazolidine dione and of dimethylethyloxazolidine dione on seizures and on the blood, Proceedings of Association for Research in Nervous and Mental Disease **26**: 1946.
10. Gayle, R. F., Jr., Lynch, J. P., and Scherer, J. H., Another fatality following the use of tridione and an hydantoin, Virginia M. Month. **75**: 6: 288–291, June 1948.
11. Braithwaite, R. F., A fatal case of agranulocytosis associated with tridione therapy, Brit. M. J. **1**: 4539: 14, January 3, 1948.
12. Carnicelli, T. J., and Tecleschi, C. G., Fatal acute pancytopenia following tridione treatment, N. England J. M. **238**: 10: 314–317, March 4, 1948.
13. Davis, J. P., and Lennox, W. G., A comparison of paradione and tridione in the treatment of epilepsy, J. Pediat. **34**: 273–278, 1949.

JUDGE RULES IN FAVOR OF ARMY IN NEW CONTEST OF DOCTOR-DRAFT LAW

The AMA Washington Letter, No. 36

In the first legal contest under the newly amended doctor draft law, a federal district court judge has ruled that the law passed by Congress last June does not make it mandatory for the armed services to commission a physician or dentist called up under the amendment. On a second issue of whether the Army must, therefore, give the doctor a discharge when he requests it, the question was not as clear cut. The judge held the petitioner (a 37-year-old dentist) had not contended he was inducted or being held in service unlawfully. The case, which is expected to be appealed, was heard in an Alexandria (Va.) court before Judge Albert V. Bryan.

The dentist, Dr. Herbert L. Nelson, was inducted May 28. On two occasions in filling out applications for commission he declined to state whether he had been a communist or a member of a communist organization. Subsequently, according to further testimony, he filed a statement admitting membership in the Young Communist League while in college and later in the International Workers Order. The Army informed the court that upon completion of basic training, Dr. Nelson would practice dentistry in the Army, probably at Fort Lee, Va., but that he wouldn't be commissioned nor allowed to handle any restricted or confidential material. Attorney for Dr. Nelson argued that if his client is to be retained on duty, then the Army is required to commission him in light of the new amendment. It states a physician or dentist "shall, under regulations prescribed by the President, be appointed, reappointed, or promoted to such grade or rank as may be commensurate with his professional education, experience, or ability." The court did not agree. The petition for a writ of habeas corpus was denied.

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

Dr. John C. Devers has opened an office for the practice of medicine at 134 East Main Street, Frostburg, Maryland. Dr. Devers, a Navy veteran of World War II, is a graduate of Gettysburg College and the Medical School of Georgetown University. He served as an interne at Geisenger Hospital and Foss Clinic, Danville, Pa. While in the armed forces he served three years in the Navy Medical Corps.

Dr. James G. Stegmaier, 122 S. Centre St., Cumberland, has been made a Fellow in the American College of Surgeons. Dr. Stegmaier graduated from the University of Maryland Medical School in 1942 and served his internship at Mercy Hospital, Baltimore. As a commissioned officer in the U. S. Army, he was called to active duty in August, 1943 and upon discharge re-entered Mercy Hospital as Assistant Resident Surgeon in 1946 and Resident Surgeon from July, 1949 to June 1950, after which he entered practice in Cumberland.

Dr. George M. Simons has returned to Cumberland, after having served 6 months with the U. S. Army in Munich, Germany. Dr. Simons was in charge of the dispensary in the Munich Hospital and holds the rank of Captain in the Reserves.

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

Robert Kimberly, Treasurer, reports that approximately seventy-seven per cent of the Baltimore City Medical Society members have paid the State Assessment of ten dollars. Probably more will pay now the summer is over. Paul Carliner and his special committee on the revision of the dues have done some effective work, and the appropriate action will probably have been taken in October at Bethesda, a month or two before this reaches print.

The Committee of Postgraduate Programs, under Harry M. Robinson, Jr., is developing a Fall program that will soon crystallize.

A closed TV program for November 5, from the University Hospital, may be sent as well to Wilmington if present plans work out. The Read Drug and Chemical Company is sponsoring the Baltimore part of the Clinics.

Baltimore City Society's new Constitution and By-Laws will be available for the December meeting.

BALTIMORE COUNTY MEDICAL ASSOCIATION

DONALD L. SOMERVILLE, M.D.

Journal Representative

At the June meeting of the Baltimore County Medical Association, held at Pikesville's Ames Methodist Church, Dr. A. Bradley Daugharthy, of Halethorpe, presented to the members one of his lifelong patients, Miss Mary V. Hughes. Miss Hughes is the charming recipient of this year's nursing scholarship. She graduated in the top tenth of her class at Catonsville High School, and has chosen Johns Hopkins School of Nursing to continue her professional training. We shall follow her career with great interest. From the impression left with the Association, she should do well.

The members gave special recognition to Dr. George S. M. Kieffer on the event of his completion of the first 50 years of practice. Dr. Kieffer's calm, distinguished mien gives the lie to those who hold that the practice of Medicine is one not compatible with an unhurried and contemplative view of life, both as observed and as experienced.

At this same meeting we were privileged to hear Dr. Harry Porter expound most helpfully on the common diseases of the ear.

The following new members were voted into the Association: Dr. R. Donald Eney, Dr. Frederick E. Phillips, Dr. Timothy G. Williams, Dr. J. Jay Platt, Dr. Clarence E. McWilliams; Associate members: Dr. Samuel Whitehouse, and Dr. Arthur C. Tiemeyer.

CARROLL COUNTY MEDICAL SOCIETY

W. H. FOARD, M.D.

Journal Representative

The first fall meeting of the Carroll County Medical Society was held at Hoffman Inn, Westminster on September 16th with 22 present.

Our guest speaker was Dr. Robert Furie, Director of the Laboratory at Frederick Memorial Hospital and Medical Examiner of Frederick County. Dr. Furie reviewed the history of the Coroner and the Medical Examiner as we have it here in the State of Maryland. He gave us some very helpful information, so that we would be better able to determine the cases that should and the cases that do not fall in the province of the Medical Examiner.

PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

JOHN M. WARREN, M.D.

Journal Representative

For the past three months, this Society has been on summer adjournment so news has been kind of sparse.

The Prince George's County Medical Society held its Annual Golf Tourney on July 11. It was, as always, a great success, and quoting Dr. Warren, "I do not know when our members have a better time together than at these informal get-togethers."

At the September meeting, Dr. Welch, who is heading the Bureau of Medical Services for Maryland's Civil Defense Section which operates out of the State Department of Health, gave a brief outline of this State's efforts to date. He stressed that the State plan is predicated on the theory that no duplication will be made of existing facilities and that defense supplies will be useful for other purposes as well. With Dr. Welch leading the way, the Committee on Civil Defense of the Prince George's County Medical Society, headed by Dr. William Brainin, is to be vastly enlarged. Men from outside of the Society area—hospital superintendents, et cetera—will, no doubt, be called upon to serve so that the County will not be caught napping in reference to the medical service for Civil Defense.

Dr. Jack Sugar is spearheading the plans for a county-wide emergency medical call system. This is in the questionnaire stage and later reports will have more details regarding the System.

DR. KEEFER SWORN IN AS MEDICAL ASSISTANT, STARTED WORK SEPTEMBER 9

The AMA Washington Letter, No. 33

Dr. Chester S. Keefer of Brookline, Mass., was sworn in August 12 as Special Assistant (Health and Medical Affairs) to the Secretary of Health, Education, and Welfare in ceremonies attended by top officials of the department. Dr. Keefer explained that he has taken a temporary leave of absence as physician-in-chief at the Massachusetts Memorial Hospital and as Wade Professor of Medicine at Boston University School of Medicine. After a Canadian vacation, he will start work in Washington September 9. Dr. Keefer said he would devote as much time to the post as it required, but he indicated that once he became "set in the job," he would divide his attention between Washington and Boston. He does not plan to move his family to Washington. The day after the swearing-in ceremonies, Secretary Hobby entertained at luncheon for a group that included Dr. Keefer, Under Secretary Rockefeller, Surgeon General Scheele and four top officials of the AMA, President Edward J. McCormick, President-elect Walter B. Martin, Dr. Dwight H. Murray, chairman of the Board of Trustees, and Dr. F. J. L. Blasingame, chairman of the Board's Committee on Legislation.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

THE SELIGER COLLECTION

A fine collection of books on psychiatry and psychoanalysis from the library of the late Dr. Robert V. Seliger has recently been given to the Faculty Library through the courtesy of Mrs. Seliger. These books have greatly strengthened a weak spot in the library's holdings.

DROPSY

LOUIS KRAUSE, M.D.*

Dropsy has been known since ancient days, and was so called because it was recognized as an accumulation of fluid in the tissues, most frequently in the legs, this because of their dependency and gravity. Undoubtedly, it had been known since time immemorial.

Emphasis, of course, has always been placed on water restriction. This can be so readily observed in the ancient literature and even in modern literature. Recently, the emphasis has been shifted to the anchor that always fixes water in the tissues, namely Sodium. Now we see this condition responding more and more to treatment with the restriction of Sodium and the use of substances which displace Sodium. In these United States, we are using 10–20 times the amount of salt today than is required physiologically.

One could go on at length about the history of salt, but suffice it to say it was very difficult to obtain in the ancient days, used under very sacred conditions, and frequently paid out as wages. Interesting enough, our word *salary* comes from the fact that the Roman soldier was usually paid with a sack of salt instead of coins. This sack of salt was called *salarium*, hence our present term of *salary*.

To leave the seacoast anywhere except the United States, is to leave your source of salt. Wars have been fought over the presence of salt mines, and the course of history in portions of Europe has been changed as the result of the struggle for the possession of salt. The virtue of salt, being never indifferent and adding positivity to the medium in which it is, has been carried over into speech and human relationship, with such expressions as, "The salt of the earth" or "Let your speech be always with grace, but seasoned with salt" or the other expression used in arranging guests at a banquet table placing some "above the salt" and others below it.

Salt was used ceremoniously. Newborn babies were rubbed with salt (Ezek. 16:3). The Roman Catholic Church today still rubs the lips of the babies to be baptized with salt. The interpretation differs over the ages, and this custom goes back even before the days of Christianity and the Bible.

Today, we look upon salt as an electrolyte that should be maintained at a certain level in balance with other electrolytes. This is the bio-chemical approach to the control of dropsy.

The following list of books covers the story of dropsy from the past to the present:

Allston, W., An inaugural essay on dropsy, or the hydropic state of fever. Philadelphia, William W. Woodward, 1797.

Ayre, J., Pathological researches into the nature and treatment of dropsy. 2d ed. London, 1829.

Bacher, G. F., Recherches sur les maladies chroniques, particulièrement sur les hydropisies, et sur les moyens de les guérir. Paris, Thiboust, 1776.

Basham, W. R., On dropsy. London, 1858.

Blackall, J., Observations on the nature and cure of dropsies. 1st American ed., Philadelphia, James Webster, 1820. 2d ed., Philadelphia, 1825.

Chapman, N., Lectures on eruptive fevers. Philadelphia, Lea and Blanchard, 1844.

Christison, R., On granular degeneration of the kidnies. Edinburgh, 1839.

Fleming, G., Disputatio medica inauguralis, de hydrope ascite. Utrecht, F. Halma, 1689.

---

* Chairman, Library Committee.

Hamilton, W., De anasarca. Edinburgh, 1773.

Hart, H., De anasarca. Edinburgh, 1773.

Maclean, L., An inquiry into the nature, causes and cure of hydrothorax. 1st American ed., Hartford, 1814.

Monro, D., An essay on the dropsy and its different species. 2d ed., London, Wilson, 1756.

Monro, D., An essay on the dropsy, 3d ed., London, 1765.

Newman, R., Outline: pathological and practical views of hydropic diseases. Winchester, Davis, 1822.

Newnan, J., An inaugural dissertation on general dropsy. Philadelphia, Parry Hall, 1793.

Osborne, J., Nature and treatment of dropsical diseases. London, 1837.

Piaggio Blanco, R. A., Las ascitis, por los doctores Raul A. Piaggio Blanco, Carlos Sayagues Laso, y Federico Garcia Capurro. Barcelona, Salvat, 1944.

Sermon, W., A friend to the sick: or, the honest Englishmans preservation. London, Edward Thomas, 1673.

Seymour, E. J., Nature and treatment of dropsy. London, Longman, 1837.

Spooner, W., Dissertatio medica inauguralis de ascite abdominali. Edinburgh, 1785.

Todd, R. B., Clinical lectures on certain diseases of the urinary organs. Philadelphia, 1857.

Whytt, R., Observations on the dropsy in the brain. Edinburgh, 1768.

Withering, W., An account of the foxglove, and some of its medical uses. Remarks on dropsy, etc., Birmingham, G. G. J. and J. Robinson, London, 1785.

PHS DETERMINING COST OF FREE MEDICAL CARE FOR U. S. PERSONNEL

The AMA Washington Letter, No. 38

As an outgrowth of a budget dispute over the free care of merchant seamen in Public Health Service hospitals, a study is being made to determine what it costs PHS each year to care for patients turned over to it by other government departments. The issue arose after the Budget Bureau told the Department of Health, Education, and Welfare to prepare its next budget excluding the care of merchant seamen, which has been considered a federal responsibility for about 150 years.

Secretary Hobby informed the Bureau she would comply, but that she would also have to determine the costs to PHS of caring for thousands of other patients for whom the federal government has assumed responsibility. She added that the review will consider, among other things, whether her department should not be reimbursed by the other federal departments for this hospital care.

Mrs. Hobby noted that the Treasury Department's Coast Guard personnel also are treated free in PHS marine hospitals, as are employee compensation cases of all departments under a program handled by the Labor Department. Because merchant seamen make up about 40 percent of all cases in the 16 marine hospitals, PHS plans to close up all these hospitals if it is denied funds to care for the sailors. This would require the government to make other arrangements for the care of hospital and dispensary patients from other government departments, who average about 10,000 per day. Where the seamen would receive care probably would be determined by the unions and the shipping lines.

Health Departments

BALTIMORE CITY HEALTH DEPARTMENT

Baltimore's Decline In Tuberculosis Mortality

A recent analysis of the vital statistics for the first half of 1953 indicates that a substantial decline in tuberculosis mortality has been recorded when compared with the experience of the first six months of 1952. For the period January–June of the present year, 150 deaths were ascribed to tuberculosis of all forms. The number recorded for the equivalent period last year was 240. This drop of 38 per cent constitutes one of the most dramatic advances which we have made in Baltimore in the fight to control tuberculosis. It is not possible to state exactly which factors are associated with this marked decline. However, studies presently in progress, give indication that the program of treating patients with streptomycin at home, while they await hospitalization, may be a significant element in preventing rapid and early death among acutely ill tuberculosis cases. The relatively high standard of living enjoyed by a wide proportion of the population and the increasing availability of beds and effectiveness of care in tuberculosis hospitals are additional factors which may account for the sharp decline in tuberculosis mortality. If the tuberculosis mortality experience for the first six months of 1953 continues during the last six months, it is estimated that the death rate for this disease will be 19 for 100,000 population for the white segment of the population and 70 for the colored population as compared with rates of 24.0 and 104.1 which were recorded in 1952.

Huntington Williams, M.D.

Commissioner of Health

ARMY TURNING OVER 450 PHYSICIANS TO NAVY, AIR FORCE

The AMA Washington Letter, No. 37

The Army, which had a physician-troop ratio of 3.61 on September 1, has begun redistribution of 450 newly commissioned physicians to the Navy (3.69 ratio) and Air Force (3.10 ratio). If these medical officers don't ask for interservice transfer, "then it may be necessary to detail some of them," Defense officials state. Overall ratio for the armed services September 1 was 3.49, according to the department. Last January the Health Resources Advisory Committee recommended the doctor ratio be reduced to 3.0, and in May Secretary of Defense Wilson directed that this ratio be reached by June 30, 1954. As late as June of this year, however, the ratio was 3.45. Since July 1 the department has stopped counting interns and counts only half of its residents in arriving at the doctor ratio. Previously, both groups were counted in full. On September 1, services listed 555 interns, 769 residents.

The redistribution program was announced simultaneously with disclosure that the military was halting drafting of physicians for an indefinite period. The department explained that it had so many volunteers after extension of the doctor draft and issuance of August call for 542 physicians, it did not have to resort to the draft. The department also said many doctors entitled to release under the new law are staying on, and that there are fewer deferments for professional training.

State of Maryland Department of Health

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, October 2-29, 1953

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS
																			Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County	7	—	—	1	—	—	9	14	4	—	2	—	—	1	9	—	13	—	6
Anne Arundel	1	—	2	—	1	—	3	3	2	—	—	1	—	1	1	4	5	—	1
Howard	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	1	—	—
Harford	2	—	—	2	—	3	1	2	—	—	—	—	—	—	2	—	—	m-1	—
Carroll	—	—	—	1	—	—	—	1	—	—	—	—	—	—	2	—	—	—	1
Frederick	—	—	—	1	—	—	—	1	—	—	1	—	—	—	—	—	3	—	1
Washington	—	—	1	—	—	—	—	—	—	—	1	—	—	—	5	—	1	—	1
Allegany	—	—	—	3	—	—	—	1	—	—	1	—	—	4	3	—	—	—	2
Garrett	2	—	—	4	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Montgomery	4	—	—	1	4	—	5	8	3	1	5	—	—	—	6	—	3	—	—
Prince George's	—	—	—	4	—	—	1	4	1	—	3	—	1	—	12	—	4	c-1	—
Calvert	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Charles	—	—	1	—	2	—	—	—	—	—	—	—	—	—	5	—	—	—	—
Saint Mary's	—	1	2	2	—	—	—	—	—	—	1	1	—	—	—	—	1	—	—
Cecil	1	—	—	1	—	—	—	—	1	—	1	—	—	—	1	—	2	—	—
Kent	—	—	—	4	—	—	4	1	1	—	—	—	—	1	1	—	—	—	—
Queen Anne's	—	—	—	—	—	—	—	4	2	—	1	—	—	—	2	—	—	—	1
Caroline	1	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	2	—	—
Talbot	—	—	—	—	—	—	—	1	—	—	—	—	—	—	1	—	—	—	—
Dorchester	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1	—	9	—	—
Wicomico	1	—	1	—	19	—	2	—	—	—	—	—	—	—	3	—	11	—	—
Worcester	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Somerset	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	1	—	—
Total Counties	21	1	7	24	26	3	26	40	14	1	17	2	1	9	56	4	57		13
Baltimore City	27	0	6	9	35	3	52	14	8	0	17	3	0	31	96	16	566	a-1	18
State																			
Oct. 2-29, 1953	48	1	13	33	61	6	78	54	22	1	34	5	1	40	152	20	623		31
Same period 1952	22	1	7	16	18	5	25	59	56	0	43	4	1	7	174	15	627		34
5-year median	34	4	4	—	23	1	23	38		2	38	4	2	60	189	57	662		33
Cumulative totals																			
State																			
Year 1953 to date	2750	11	1439	430	1554	66	2324	287	203	24	2224	29	10	336	1957	132	6779		605
Same period 1952	2759	8	840	198	9088	76	940	163	133	28	880	19	14	172	2247	164	6210		542
5-year median	3077	63	530	—	4013	61	1613	194		56	923	30	36	684	2302	724	6347		511

a = amoebic dysentery.
c = congenital syphilis under 1 year of age.
m = malaria contracted outside of Maryland.

Blue Cross - Blue Shield

ENROLLMENT REGULATIONS FOR BLUE SHIELD

R. H. DABNEY*

A recent survey of Blue Shield participating physicians in a large nearby State revealed that the Plan's enrollment regulations and procedures were subjects involving the most questions, comments, and complaints. While the doctors' interest in the problem clearly indicated that they wanted Blue Shield to grow—and grow faster than it had—it also revealed some misunderstanding of why it is necessary to set certain controls on the enrollment of subscribers.

Basically, enrollment regulations are a means of underwriting business to obtain an average selection of risk, which in turn will assure sound financial operations and the maintenance of a modest subscription charge. These regulations take two principal forms: first, the insistence on a percentage of participation in employed groups—50% of employees in groups over 200, 60% in groups of 30 to 200, and so on to 100% for small groups of five persons; and second, the establishment of specific times, usually twice a year, when additional applications are accepted. Actually, in comparison with other Blue Shield Plans and programs offered by commercial carriers, our requirements in Maryland are not severe.

No one can deny that these regulations, unfortunately, make it impossible for some worthy persons to join up. On the other hand, it is obvious that without percentage requirements the chronically ill would sign up first and would soon outnumber the healthy ones, leaving the Plan with an adverse overall risk. If Blue Shield is to fulfill its purpose as a community program to assist those in modest circumstances to finance the costs of hospitalized illness, and is to maintain its modest subscription rates, then it must continue to enroll a goodly number of healthy people to balance the numbers who are going to need medical care. Groups with low utilization must be enrolled to balance the groups with high utilization.

To date, Blue Shield, like Blue Cross, enrolls new members only through groups. We hope at some future date to be able to offer non-group enrollment for the self-employed and for those who work where there are less than five employees. Such a program will necessarily require underwriting of individual risks, which, in turn, will add to the cost for the subscriber.

The future success of Blue Shield, we believe, lies not in accepting members indiscriminately, but in convincing the people that Blue Shield—the doctors' program—is the best there is; that through membership in this non-profit Plan they will receive comprehensive protection, the maximum return in benefits for their subscription dollar, and the best in medical care.

---

* Executive Director, Maryland Hospital Service, Inc. and Maryland Medical Service, Inc.

THE DOCTOR IS THE KEY TO THIS BLUE CROSS PROBLEM*

THE SUN, BALTIMORE, MARYLAND, SEPTEMBER 11, 1953

Speaking before the American Hospital Association in San Francisco, Dr. John W. Cline, former president of the American Hospital Association, warned that overuse of hospitals by subscribers to the Blue Cross is burdening the prepaid medical-care programs and reducing their efficiency. Dr. Cline stated that some patients insist on the top limit of the service on the ground that they have paid for it and are entitled to it.

Inquiry reveals that the problem exists here in Maryland. The incidence of going to the hospital in relation to the total membership in Blue Cross is rising. However, the rate in Maryland is lower than the national average and always has been.

The incidence rate, of course, plays a vital part in determining the cost of insurance to each member. The more the hospitals are used, the greater the cost to them. If hospitals are used more than is necessary the result may be a raising of the insurance rates or reduction of the services offered.

One possible solution of the problem would be to include a deterrent in the contract, such as requiring an initial payment by the patient. Another would be to follow the practice of the commercial companies and exclude those individuals regarded as poor risks. But that plan would destroy the main purpose of Blue Cross, which is to insure as many persons as possible.

The more the problem is studied the more evident it becomes that the doctor is the key man. No patient can be entered in a hospital under Blue Cross without his indorsement. He knows whether hospitalization is really necessary. Where it is not, it is up to him to acquaint the patient with the importance of keeping the incidence rate low for his own sake, for the sake of the profession and for the medical-care program as a whole. This is a matter in which patient, doctor, hospital and Blue Cross all have a stake.

---

* Appreciation is extended to The Sun for permission to reprint this article.

VA HOSPITALIZING MORE NON-SERVICE CONNECTED CASES

The AMA Washington Letter, No. 40

Latest statistics from Veterans Administration show the agency is reducing its lists of service and non-service connected cases awaiting hospitalization. In August 1952 service-connected cases waiting admission totaled 143. During July and August of this year they numbered only two. At the same time VA is getting more and more non-service connected cases into its hospitals. In August 1952 VA listed as waiting hospitalization 22,341 cases it described as "other than disabilities adjudicated service-connected." By July of this year only 20,370 were still waiting treatment, and in August only 17,874.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. CHARLES H. WILLIAMS, *Auxiliary Editor*

HOW TO WORK WITH WOMEN'S CLUBS*

MRS. SHELLEY DAVIS

Woman's Auxiliary, Medical Association of Georgia

With continuing wars depleting the ranks of our nation's manhood, more and more women are rising to positions of importance in business, industry and politics. No longer does madam concern herself merely with sewing a fine seam. Today she must consider the bank account, taxes, economic trends, and finally, protecting her health and that of her family.

Focus on Women

From time immemorial, women have been reminded that they know nothing of world affairs, and so today, women's clubs bring women a form of packaged-learning. In one hour's time, hundreds of women can learn enough from a well-prepared speaker to set them thinking for months.

Intelligent women's groups carefully plan diversified programs well in advance. The General Federation of Women's Clubs, which boasts a membership of well over eleven million women, is the largest group of organized women in the world. Yet it has direct contact with the smallest women's club in the most rural community. What a terrific potential for programming!

Now, just suppose that Mrs. Oscar Ahlgren, president of the General Federation of Women's Clubs, urged her state and district presidents to plan one local health meeting during the year. Then suppose the health and welfare chairmen of the local clubs, plan a meeting and invite the local county medical society to present a program on voluntary medical care insurance or labor costs in medicine—any number of subjects with local application. This could be a medical public relations school!

I wonder what the average doctor-speaker would do if his typewritten paper were suddenly snatched away from him? Perhaps he would no longer be guilty of muttering in his beard. Perhaps he would convey a feeling of sincerity and human interest by looking at his audience instead of a sheet of medical statistics.

Now, in every community, the League of Women Voters is busily preparing information on current legislation. How much easier the job would be if the local county medical society's committee on legislation would invite representatives from the League of Women Voters and explain the ramifications of proposed health and medical legislation.

Another great source of power today lies in such women's service organizations as the Pilot Club, the Business and Professional Women's Clubs, the Quota Club, the Women's Chamber of Commerce, the Women Lawyers Associations and so forth.

Theirs is a very busy schedule, but they fill a definite niche in the community. How much closer medicine could work with these groups if local and state medical society officers invited these club members to an informal get-together and offered vital, current woman-interest material for monthly release.

Even though many physicians shun publicity, extra work and the criticism of constituents for taking leadership, service on a community health council is a golden opportunity for doctors to regain deserved community respect.

Perhaps one of the most unexplored potentials for good public relations in women's organizations is the use of the thousands of women physicians. There is a unique tie-in with wives and mothers. And, at the same time, representation of the American Medical Association. Surely, with little public relations briefing, their entries would be legion. Why not utilize this wealth of ability already within the ranks of medicine?

---

* "Putting PR to Work—A Digest of Proceedings of the First Medical Public Relations Institute, September 4 and 5, 1952, Chicago, Illinois." Reprinted by courtesy of American Medical Association.

Other organizations such as the American Association of University Women include in their yearly programs some phase of education. Rarely does a program chairman pass up a good movie short. Here lies another opportunity to tell medicine's story.

And last, but by no means least, is the Woman's Auxiliary. Every doctor's wife, whether she wants to be or not, is a spokesman and a public relations agent for the medical profession. She no sooner walks into a PTA meeting or the country club than she is asked what doctors think of the cobalt bomb or polio immunization. Her name is read as chairman of health committees without her consent. If she pleads home duties, she is guilty of shirking community responsibility. Since she learns this is part of her life, why not make it good.

In the Auxiliary she finds solace with other doctor's wives who must play second fiddle and share their husbands with just everybody. But she also finds how utterly interesting it is to work in civic activities. And so, understanding cements family unity and creates a vital, energetic medical auxiliary.

Where there is no medical auxiliary, the doctors say won't you girls get together and help us out? Since the Divine Maker created Eve, women have played a part in shaping the pattern of destiny. With just a little honest persuasion, they can be invaluable aids in shaping the destiny of American medicine.

COMPONENT NEWS

I am sure you will be pleased to learn of the release of Dr. Alexander M. Boysen from a Korean prison camp. Dr. Boysen was captured in 1950, and is the son-in-law of Dr. and Mrs. Gerald Le Van, Boonesboro, Maryland.

Mrs. LeVan is the President of the Woman's Auxiliary to Washington County.

CAPS AND BELLES

Mrs. E. Roderick Shipley, Program Chairman, and Mrs. Conrad Acton, Corresponding Secretary of the Woman's Auxiliary to the Baltimore City Medical Society, report a premiere showing of the film sponsored by the "Nurse Recruitment Committee," on Wednesday, December 2, 1953, at 11:00 a.m., at 1211 Cathedral Street.

This film contains scenes from most of the hospitals in Baltimore and many of the surrounding territories.

INCREASED MEMBERSHIP

Mrs. Thomas E. Wheeler, President of the Woman's Auxiliary to the Baltimore County Medical Association, has just presented Dr. Wheeler and the Auxiliary with a new member—Melannie Lorraine, weight 8 pounds.

WASHINGTON COUNTY AUXILIARY STARTS PUBLICATION

The Woman's Auxiliary to the Washington County Medical Society has started to issue a bulletin four times a year to all members. The first issue brought news that the Western Maryland Chapter of the Maryland Motor Truck Association, Inc. had presented to the Auxiliary a citation for meritorious service for their "unselfish devotion of time and energy to the interest of safety in Hagerstown and Washington County." This certainly shows great work and talent and wonderful Public Relations for our Auxiliary.

TIPS 'N TOPICS ABOUT TODAY'S HEALTH

Reprinted from July, 1953, issue Woman's Auxiliary to the American Medical Association

—"SACK OF CANDY" IDEA IS SUCCESSFUL HERE—

Eight of the obstetricians of Dade County, Florida, cooperated last year in a program of getting TODAY'S HEALTH into the hands of young parents. As the bill for the baby was paid in full, a gift subscription was sent to the mother and father of the baby as a thank-you (sack of candy) from the obstetrician. All the doctors who participated in this scheme say that their patients were most grateful and have mentioned the gift more than once.

The important thing about this program is that it doesn't stop with the one-year gift subscription from the obstetrician, but the parents are potential customers for the Dade County Auxiliary, and as the subscriptions come due this year, the auxiliary will approach this group for renewals.

Ancillary News

PHARMACY SECTION

LET'S BRING IT OUT IN THE OPEN

L. M. KANTNER, PHAR. D.[1]

In recent months there has been widespread use of the term "Substitution" applied to prescription practice. Pharmacists are being accused, and unquestionably correctly, of using on prescriptions a product other than that which was specified. The accusation emanates largely from pharmaceutical manufacturers, who charge the offense ranges from substituting one brand for another to the use of out and out counterfeit preparations.

Without fear of contradiction, I believe this offense is practiced by a small minority of pharmacists, but even that number is too large. Pharmacists, who have no part in such acts, are strong in their condemnation of these practices and are active in exposing and penalizing the participants. Economically, it is a type of competition that cannot be competed with by ethical pharmacists.

At the outset, let it be crystal clear that the writer does not condone even the odor of substitution when it is applied to dispensing medicines except in emergencies, and these are so rare as to be dismissed from further comment.

Although there may be some points raised here that can be claimed as contributing factors leading to substitution, they should not be construed as defending the practice in any way as will be pointed out later.

So far as pharmaceutical manufacturers complaining about substitution, this deals primarily with the economics involved. The drug industry operates in free and open competition, as it should, and in this respect does not differ from other industries.

Because of this freedom, manufacturers duplicate their competitors' preparations with impunity. With the result that there are numerous preparations on the market that are identical so far as active ingredients are concerned, and the difference of one product from another is largely that of color or flavor.

From a realistic standpoint, there could be no criminal offense in the interchanging of such preparations. However, as the prescriber is the figure in command, the pharmacist has no alternative than to explicitly carry out his order without the prescriber's authorization to do so. In this respect, the average physician is approachable to permit the use of an identical brand to the one prescribed, provided assurance is given that the brand suggested is a product of as reliable a manufacturer as the one whose product was specified.

As to duplications, it is interesting to note what a former vice-president of one of the leading pharmaceutical houses has to say, and I quote:

"Pharmaceutical manufacturers must take the initiative in ending the economic waste and dilution of effort in marketing that results in duplication of products."

He further stated that the original work on isoniazid was done by two or three companies, and by the time the product was ready to put on the market there were thirty-eight or so brands.

Now, it stands to reason that no pharmacy could be expected to carry thirty-eight brands of an identical preparation. However, manufacturers give their products a trade or brand name notwithstanding the products are identical.

Another example concerns the antibiotic, erythromycin, a discovery that restricts its manufacture to three companies. Two of the manufacturers elected to identify their product with a brand name, while the third was satisfied to use the generic name. Although all are identical, each manufacturer coats the tablets a different color as a mark for identity. If a pharmacist carries two of the brands in stock and receives a prescription for the third manufacturer's tablet, which he does not have, one of the other two brands cannot be used unless the prescriber authorizes the change. Does it or does it not make sense?

---

[1] Secretary, Maryland Board of Pharmacy.

Up to this point, the only type of manufacturers that have been considered are those of the highest order whose reputation is reflected in their products.

Unfortunately, there has developed a type of manufacturer who relies on counterfeiting. This type develops nothing worthy of consideration. His survival depends on imitating other products and having them used for substitution purposes. Some of these manufacturers have become so bold as to catalogue their products, and in juxtaposition the preparations they can be substituted for are listed.

As stated before, only a small number of pharmacists are guilty of substitution. This is not a glib remark. There are records to substantiate it. Manufacturers are spending large sums of money for investigations, and the records show that substitutors are greatly in the minority. The pharmacists who do substitute, for reasons quite understandable, have little opportunity to do so because their prescription business is meager.

There are about 50,000 pharmacies scattered over the United States, and if 20 per cent practiced substitution, their purchases would be insufficient to support counterfeiting manufacturers.

The question arises: Where do these counterfeit products find a market sufficient to support operation? There is every reason to believe it is not in retail pharmacy.

SECTIONAL MEETING OF THE AMERICAN COLLEGE OF SURGEONS

February 1 to 3, 1954

Hotel Charlotte, Charlotte, North Carolina

Preliminary details of the program give promise to a very interesting meeting.

For additional information, contact Dr. E. Roderick Shipley, Medical Arts Building, Baltimore 1, Maryland.

JOINT ANESTHESIA STUDY GROUP

Otto C. Phillips, M.D., *Chairman*

Wednesday, December 16, 1953, 8:30 p.m.

Guest discussants. Dr. Otto C. Brantigan, Associate Professor of Surgery, University of Maryland School of Medicine, and Dr. James Maloney, Assistant in Surgery, The Johns Hopkins Hospital.

Coming Meetings

CANCER SECTION

Arthur G. Siwinski, M.D., *Secretary* Edwin H. Stewart, Jr., M.D., *Chairman*

Wednesday, December 9, 1953

Dinner Meeting

U. S. Public Health Service Hospital

Time and Program to be announced.

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty

Richard W. TeLinde, M.D., *Chairman* Beverley C. Compton, M.D., *Secretary*

Thursday, December 17, 1953, 5:00 to 6:00 p.m.

1211 Cathedral Street, Lower Floor

MATERNAL MORTALITY COMMITTEE

Thursday, December 17, 1953, 4:00 p.m., Osler Hall

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and the Baltimore City Health Department.

BALTIMORE CITY MEDICAL SOCIETY

WETHERBEE FORT, M.D., *President* EDWARD F. COTTER, M.D., *Secretary*
LEWIS P. GUNDRY, M.D., *Vice-President* ROBERT C. KIMBERLY, M.D., *Treasurer*

ANNUAL MEETING

Friday, December 18, 1953, 8:30 p.m.

Reports of Committees and Election of Officers

SYMPOSIUM ON TUBERCULOSIS

ROSS L. MCLEAN, M.D., *Moderator*

Participants:

Colonel Carl W. Tempel, MC., Chief, Medical Service, Fitzsimons Army Hospital, Denver, Colorado

J. Maxwell Chamberlain, M.D., Associate Professor of Surgery, Columbia University College of Physicians and Surgeons, New York City

Mr. William Steenken, Jr., The Trudeau Foundation for the Clinical and Experimental Study of Pulmonary Disease, Trudeau Laboratory, Trudeau, N. Y.

Oscar Auerbach, M.D., Chief, Laboratory Service, Veterans Administration Hospital, East Orange, N. J.

Smoker

Maryland STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 2 *December, 1953* NUMBER 12

ANNUAL MEETING—MEDICAL AND CHIRURGICAL FACULTY*

Wednesday Evening, April 29, 1953

Osler Hall

Dr. Maurice C. Pincoffs: One of the features of this last evening of the meeting, in recent years, and the very pleasant privilege for the President has been to give to the membership and their wives an opportunity to see and hear the President of the Woman's Auxiliary of the Medical and Chirurgical Faculty of the State of Maryland. It is hoped that she will give a brief review of the work of the Woman's Auxiliary. Their work is deeply appreciated by the Faculty. I wish to add my personal compliments for the memorable meeting in the middle of the day.—A very beautiful and pleasant luncheon that gave many of the husbands as well as members of the Auxiliary a chance to hear what I thought was a very remarkable and inspiring speech by the President of the American Medical Association, Dr. Bauer.

You will note on your program that we were to have had the pleasure of having him here at this meeting tonight, but those of you who were at the luncheon know that by this time he is very nearly landing in New Orleans. I turn, therefore, to Mrs. Williams who is this year the very efficient, energetic, and able President of the Woman's Auxiliary of the Medical and Chirurgical Faculty, Mrs. Williams.

Remarks of Mrs. Charles H. Williams

Mrs. Charles H. Williams: To the Faculty, my sincerest thanks for the lovely flowers that I am wearing this evening.

When my oldest son was just four years old, his Sunday School teacher was very discouraged with his unnecessary activity in her class. One day while she was giving out her Bible leaflets, my son kept jumping up and down yelling for his copy. In desperation she started on a little lecture just for him. She ended this by saying: "John, please, can't you learn to wait? You just must learn patience. Don't you know what patience is?" "Oh yes," my son explained very quickly, "sick people." I hope you will have a little patience with me, tonight, because I simply must review some of the highlights of your Auxiliary year.

Our Auxiliary, in an effort to get out the votes, joined the Ballot Battalion, a non-partisan group. We organized baby-sitting centers in doctors' offices and churches all over the city. One of our counties took care of telephone calls for their entire area for all information and service during the election day. Recently we were notified that our work helped the battalion win a major award in a contest sponsored by the American Heritage Foundation.

---

* Transactions of 1953 of Medical and Chirurgical Faculty are completed with this issue except for the Presidential Address of Dr. Maurice C. Pincoffs.

The booklet "Winning Ways With Patients" was placed in many business offices and high schools for training secretaries and receptionists. Four of our counties sponsored Health Exhibits at Fairs. Medical literature was given out to thousands. We have worked on Civil Defense, Cancer and Medical research programs.

A resolution to honor the physician successfully passed our legislature and most county physicians were honored in some way.

Future nurses clubs were organized in many schools. We helped various other groups obtain medical films for their programs. All of our organized counties now have nursing scholarships, and one county had to cut theirs in half because the award was won by twin sisters. High schools were visited and hospital tours conducted. A nurse recruitment film is being made of our nursing schools at a cost of Twenty-Five Hundred Dollars. The fund for this was made up from contributions. A reception was held to honor the nurses in practice. Various things were done for nurses' homes, such as the purchase of television sets. One county now gives an award to the nurse graduating with distinguished all-around efficiency.

On May 12th, this year, the first future Nurses Convention in the United States will be held here in this hall. This is a scientific session modeled after the doctors convention, with films and outstanding speakers. Already we have almost four hundred written reservations for girls who are interested in nursing to attend this affair.

Last but not least we supported both of our Medical Schools by contributing to the American Medical Education Fund, and, of course, you all enjoyed the wonderful Ball on Monday evening.

To our new President, Mrs. John G. Ball, I would like to leave a story that my father repeated often to me when I was a youngster, of the two frogs that fell in a cream pitcher. One kicked a little bit and then sank to the bottom, while the other kept kicking and the first thing it knew it was floating around on top, on a ball of butter. Thank you.

Dr. Pincoffs: I have another pleasant duty, Mrs. Williams, and that is to present to you these flowers and to read this letter which I should also like to read to the audience. It comes from and it is signed by the President of the Baltimore County Medical Association and is addressed to Mrs. Williams:

> "We in Baltimore County are proud to have had you as the President of the Ladies Auxiliary of the Baltimore County Medical Association. We are further complimented that you were selected to fill the Presidency of the Ladies Auxiliary of the Medical and Chirurgical Faculty of Maryland. It is therefore a very genuine 'well done' you have earned, and now we wish to express to you our appreciation and best wishes." (APPLAUSE)

TESTIMONIAL TO DR. HARVEY B. STONE—PRESENTATION

Dr. Pincoffs: I shall now call on Dr. Chatard, who has a function to perform.

Dr. J. Albert Chatard: I am in a quandary. There is no definite indication in the program just why I am here. I am sure you are all wondering. Although I'm Treasurer of the Faculty, this is not a plea for funds or anything like that. However, as Curator I have a very wonderful duty to perform tonight.

"*The good man does, is oft interred with his bones.*" How much more pleasant it is to say nice, well meant things about one who is present; still with us; active; and much alive to all the problems of modern life! Many, many times, portraits, books and other valuable mementoes are presented to your Faculty; a long or a short while after the one so honored, has departed.

Tonight this is reversed and the one to be honored is closely with us, Dr. Harvey B. Stone. Words of praise are embarrassing to many people, but are pleasing to all of us when so clearly deserved as on this occasion; now just a few words that come from my heart, Harvey!

We have been together for many years, on many committees during our work at the Faculty. I know only too well how many times I have watched you in the Council and other meetings holding the lid down with patience, forebearance and quietly aiding the discussion to drift to its proper solution under your guidance. No one could have done a better job and all our members are deeply indebted to you for your work. My few feeble words cannot adequately express my feelings.

As Curator of our Faculty (a position very recently acquired by me) it would be amiss, if on this occasion, I did not extend to all our past and present friends and associates, thanks for the wonderful things we have inherited and must preserve for future generations. I don't think our membership fully appreciates all that is housed in these hallowed walls; so much we have and I hope much more will come in the future.

Now, it is my most pleasant duty to present to the members of the Faculty, this most beautiful silver service as a gift from Mr. and Mrs. Brinton H. Stone, Dr. and Mrs. Douglas H. Stone and Dr. and Mrs. George H. Yeager in honor of their father, Dr. Harvey B. Stone. On the oval tray is engraved, the seal of the Faculty with the notation that Dr. Stone was President, 1941, member of the Council 25 years, and Chairman of the Council 5 years.

To you now, Dr. Pincoffs, as President of the Faculty I wish to present this silver service in the name of the Stone family.

Dr. Pincoffs: I am very glad to be in the President's position to accept this very fine gift in the name of the Faculty honoring one whom I have known closely for thirty years and have been privileged to sit with in the Council of this Faculty for a long time. I shall not attempt to narrate all the history of Dr. Stone's medical life and the honors he has won. Many of us here have known him only as a modest man whom we all have trusted as to his fairness, his judgment, and his wisdom. We have looked to him for help in all the affairs of medicine in the State. Perhaps a number of you don't realize the national position he has held; how, after his service in World War I, he kept in relation to the military affairs in Washington, and throughout the entire interval between the wars; and during the last war he was called on for advice in an administrative way to the military service. Nor may you realize what an important part he has played in the National affairs of medicine, first as our delegate and later on the A.M.A. Council on Medical Education and Hospitals. We do know, I am sure, and appreciate the position he has won in his field in surgery, as a teacher and investigator and as a most able surgeon.

I am glad to say that modest as he may be and although retiring to a position way back in the hall, I am in a position to ask him to come forward now. (APPLAUSE) It is not the purpose to suddenly thrust on him a task of saying much; it is because there is another small ceremony to perform this evening in connection with Dr. Harvey Stone.

As President of the Faculty, Harvey, I have been asked by the American Medical Educational Foundation to present to you a National Award of Merit which reads:

> "To Harvey B. Stone for your outstanding contribution for the preservation and continuance of the high standards of Medical Education in the United States of America."

This Foundation is deeply indebted to Dr. Stone for his services as Vice-President of the organization and his loyal, generous and untiring support since the inception of the program to keep our medical schools free and independent institutions with continued high standards.

(PRESENTATION)

Dr. Harvey B. Stone: I am deeply touched and deeply embarrassed. You know, Dr. Chatard has quoted from William Shakespeare, I believe, and I think a part of that same speech could be modified for this occasion to read:

> "I have come to praise Caesar, not to bury him."

And I think perhaps it was easier on Caesar in the first version.

I am tremendously affected by the fact that my children who know my weaknesses and shortcomings still thought enough of me to do this. Thank you.

(OVATION)

THE CHANGING NATURE OF MEDICINE*

J. S. L. BROWNE, M.D.C.M., Ph.D., F.R.S.C., F.R.C.P. (C)., F.A.C.P.†

Dr. Pincoffs: The Ridgeway Trimble Fund Lectureship has always been a feature of the annual meeting. It is usually on the last night and it is attended by a more varied and in many ways a more charming audience than the purely technical meetings. When we invited our speaker of tonight to come here, we told him that if he chose a subject more broad in nature than any single contribution, it would fit the occasion very well. I know that you will be stimulated because Dr. Browne, Professor of Medicine at McGill University, and Director of the Department of Medicine in the Victoria General Hospital in Montreal, has in addition to his many contributions in the more technical side of medical research, always been interested in the philosophical side of medicine and has a gift of presentation that I am sure is going to be a great delight to us all. I take pleasure in introducing Dr. J. S. L. Browne.

Dr. J. S. L. Browne: When the letter from Dr. Compton came, I wanted to know whether I was to be scientific, humorous or philosophical. I did not ask to be philosophical, I was told I had to be philosophical. I've forgotten who it was who said that he tried to be a philosopher but cheerfulness would keep breaking through. I trust that cheerfulness will occasionally break through this discussion. If it doesn't you can all leave from time to time, as the musicians do in Haydn's "Farewell Symphony," if you remember.

My title is "The Changing Nature of Medicine." In French there is a phrase, "Plus ça change, plus ç'est la même chose," which means, the more it changes, the more it remains the same thing. As that is true I am not quite sure what it is I am going to talk about, regarding the changing nature of medicine.

However, a little while ago we had at the Sigma Chapter at McGill, a symposium on the "Criteria of Proof in Various Sciences." There were a physicist, a biologist who is an entomologist, a cellulose chemist, and myself. We had to have five luncheon meetings in order that we could begin to discuss with each other at all because, of course, each didn't understand a word the other said to begin with, and after about five luncheon meetings (and they were by far the most interesting part of the whole affair) the physicist suddenly said: "Hmm—yes, we used to say that light was either corpuscular or wavelength, and now we say light is light and it behaves this way; we have the operational point of view." "Why yes," said the entomologist, "We used to stick pins in bugs and say 'this is this species, this is this species, this is this species, and now we seem to find that the species tend to merge into each other and this is very awkward.' " "Why, yes," said the psychologist, "we used to characterize definite characteristics and label them and put them down and now, all sorts of difficulties have come up and we are not quite sure where we stand." At the symposium itself, Dr. David Thomson, who is Professor of Biochemistry, summed up, by saying that we used to think we could attain definite truth, and now we think that truth is a black speck in the middle of a cloud and we're not quite sure there's a speck there.

---

* I. Ridgeway Trimble Lectureship presented at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, on Wednesday evening, April 29, 1953, in Osler Hall, 1211 Cathedral Street, Baltimore, Maryland. (Transactions, 1953.)

† Professor of Medicine, McGill University, and Director, McGill University Clinic, Royal Victoria Hospital, Montreal, Canada.

It seemed to be rather an odd sort of affair to get approximate agreement between scientists of quite different disciplines as to some sort of vague thought like that, and it reminded me of what could be called the concept of "mental climate," which was used by Whitehead to indicate the ambience in which the science, the art, the politics of an era grow and develop. It seems to me in looking over a very short period of time, that certain events in medicine recently have perhaps brought forward a little bit more the kind of rather vague point of view, which was taken at that symposium.

It is a very irritating point of view, most people don't like it. I didn't like it myself very much, but I think it has perhaps been useful in at least allowing us to reconsider certain of our attitudes in medicine, and to have become perhaps not necessarily from the practical but from the theoretical point of view a little less definite than we used to be, that we knew definitely much of what there was to know.

In the following you will see I am taking part in the same way as all medical people take part in the growth of medicine. One may liken this growth to a tree which grows from a seed, branches, then flowers, goes to seed and then another tree grows and thus is continuous. Each person in the course of his development in medicine, grows along with the subject, then he flowers, then he may go to seed and then another generation comes along and as this process goes on there is a good deal of personal difficulty which goes along with the process of which I shall speak a little later.

First of all, with regard to Medicine, I think one can divide it properly into three parts: its science, its art and its spirit. Its science is what I propose to talk about first, and it has seemed to me from the educational point of view, that eighteenth century materialism become differentiated through strict nineteenth century morphological pathology into medicine. So that since man is ever desirous of certainty, and since I am now speaking of the science of medicine and not its art or its spirit, there came about a view at the beginning of this century and it still persists, that the interest in the patient was as the inverse square of his distance from the autopsy table. That, of course, was because at the autopsy table people thought they could be certain this is the way students should be taught, and the interest lay very largely along those lines. This point of view hasn't really altered; it is only altered in the way in which further facts to obtain certainty are obtained as I shall point out.

The spirit of medicine is quite a different thing. It has been present ever since one man said, "I'm not well, will you help me?" That has been from the time of primitive man until now and it hasn't altered at all, and it seems to me that the art of medicine is the application of the science of the day in the light of the spirit. The art of medicine then will also be a continuous changing thing; it will not always be the same. It is this continuous growth and changing which leads, as we shall see to misunderstanding and difficulty, and to resentment of the attitudes of different ages and of different generations. Actually the spirit changes very little; the science changes and so does the art.

From the scientific point of view we feel that in the last twenty or thirty years, our capacity to learn scientific facts about the patient before his death has been increased. Our senses have been extended in many ways, and physiology, biochemistry, biophysics, etc., have come to be applied to medicine for the obtaining of additional facts.

However, I would point out to you that since we are conditioned by our medical childhood just as surely as we are conditioned by our actual childhood, and since in most people's medical childhood and in the generation before that, the autopsy table was the sanctum of truth, one needs twenty tests to equal one autopsy table for certainty and consequently a great many tests are done and patients become scattered all over the lot of specialism and of determinism. This process has been going on for a long time. It isn't in any way new. I would point out that it is not the extension of our senses by apparatus and chemical and physical determinations which make us forget the art and the spirit of medicine; it is using them as an excuse for not thinking or feeling.

Of course, this is all very unsatisfactory, so again, people have felt that Humpty Dumpty should be put together again and what follows is in no way disparaging to the efforts of people to put him together again. It is highly desirable, but in the course of being put together again a large number of the pieces were put together but there was rather a large crack around the two parts of the egg, and if I may, I prefer to transfer the metaphor rapidly to call the crack a fence: the psychosomatic fence.

The psychosomatic fence is a bright, white-painted picket fence on a green lawn which has no fence on it, and the medical people constantly fall over the fence on one side, and the psychiatrists fall off it on the other and there isn't any fence there.

A new term has come in recently which is called comprehensive medicine, and the intention is to seal the crack up and to perceive the green lawn though whether the last will be accomplished I am not as yet sure.

In medicine, it seems to me that our tendency to have very definite views about diseases, to give them definite names and to believe that they are true entities, all of them independent of each other, has altered somewhat recently. The above is an exaggerated statement, of course, of what went on before because, the concept of the host response has certainly been considered for many years. That concept has received a considerable degree of redirection of attention to it by the concept of the adaptation syndrome put forward by Dr. Hans Selye.

Now, in essence, the concept of the adaptation syndrome states firstly, that the organism reacts in the same way to a variety of different damaging agents, for example, to cold, to morphine, to adrenalin, to fright, etc.; secondly that as you go on damaging an organism, it changes its reaction in time; and thirdly, that it matters whether the organism has been damaged before as to how it reacts to a second damage. I have no intention of going into the analysis of the scientific details of this, but those are the main principles.

The substances ACTH and Cortisone have come along with the discovery by Hench and Kendall, and they have been found to affect a very large number of apparently quite different and certainly differently named diseases. I freely confess that I, myself, and I think quite a large number of people felt that this was a very great advance, perhaps a panacea. I can remember, to misquote Shakespeare at the first ACTH conference that this came to me after the meeting:

> "To be or not to be? that is the question.
> Whether 'tis nobler in the mind to suffer
> The slings and arrows of outrageous stresses
> Or by a stroke to end them all; to A, to C,
> To T, to H, that is the question?"

Now that, of course, is the feeling which commonly happens with many new things and remedies. It does, however, remain that ACTH and Cortisone do affect symptoms and processes in the body in a vast number of apparently different diseases.

On a vacation in Gaspe in 1950, when I was trying to get away from ACTH and Cortisone, I invented an "iceberg" of disease.

As you know, an iceberg floats with about seven-eighths of its bulk below the surface. The whole of the iceberg represents the signs and symptoms of diseases as we know them. We know how diseases were named: somebody observed that somebody was sick, had certain symptoms and then listened or looked or heard or felt certain things; when the patient came to autopsy certain findings were made and after several patients had been found to have the same signs and symptoms and the same findings at autopsy, these were related, and then a name was given and this then became a disease entity.

The parts of the iceberg may be regarded as representing different diseases. Let us call one part tuberculosis, one, lobar pneumonia, one, asthma, one rheumatic fever and one, rheumatoid arthritis. The projections of the iceberg above the surface, the peaks in other words, may be regarded in two ways: first, as the overt or apparent aspects of the disease. Each individual peak may represent the special reactions of the body to the particular environmental influence—for example—all those things the body does about the tubercle bacillus and not about anything else, about the pneumococcus, about the allergen. Underneath the surface, the mass of the iceberg represents the general reactions of the body, those things described in the adaptation syndrome and I am sure a large number of others not so described. These reactions have been called non-specific but that isn't quite true; unless both the special *and* the general reactions are present, the disease is not.

If we apply Cortisone or ACTH we melt the iceberg (alter the general reactions) and that part with its peak sinks below the surface and the overt disease disappears. It is still there but it isn't apparent; when one stops treatment, the iceberg reforms and the disease appears again as for example, in the case of rheumatoid arthritis. It is also true, for example, that some of the peaks (or special reactions) can be present below the surface for years. For example, the special reactions of tuberculosis can be present in the body for many years before the overt disease appears; due perhaps to an alteration in the general reactions of the body occasioned by starvation, another acute disease or an emotional upset, can lead to the disease becoming active and apparent (to the peak appearing above the surface). We know that ACTH and Cortisone can affect the general reactions of the body and I submit that the pituitary and the adrenal have been present in the body many years before anybody discovered ACTH or Cortisone and have been reacting to stresses and that these reactions may influence the appearance, disappearance and severity of disease depending upon the special reactions present in the body at the time.

We know that psychological influences affect the output of the adrenal cortex and therefore this is one connection between emotion and the underlying broad common area of the iceberg which takes part in many diseases but which is not itself the disease. In other words it is necessary to have both the special and the general reactions for the disease to be characterized as the disease as we know it, and if you were to interfere with either the special reactions or with the general reactions, then the disease ceases to be the disease as we know it. You are well aware of the fact that if you give ACTH and Cortisone, you may so distort the disease processes that it is very difficult for our clinical judgment to recognize, or to realize its severity.

This is all of course partly speculative. It is, however, I think, the case that we can no longer say this is this disease, this is that disease, and they are all separate (as the entomologist's species). However there is an inter-relation between them though naturally the relative importance of the special or the general reactions in the disease varies under different circumstances.

There is at the moment a reaction against this concept as always happens and it has been pointed out quite clearly that the concept that the body reacts in the same manner isn't strictly true. However, the concept still has value in the sense that it does point out that in many diseases the host response is similar or the same and that by modifying that response, you can markedly alter the overt manifestations of the disease.

I might just mention the phrase I put in the abstract and that is what I described as the "net" versus the "chain" concept of causality. We have the strands of a net and let us say we have an indicator. If one of these strands breaks, the whole net is going to rearrange itself. The indicator will move, and it may move in the same direction whether it is this or that strand which breaks. So for example, if we are to conceive of edema as being the indicator influenced by so much deficiency of protein; so much retention of salt, so much anti-diuretic effect and so much something else, the relative importance of these strands of the net will vary. If we fix our attention on one strand and find low blood protein and say—ah, that is the cause of the edema—and so we hang our hat and fix our therapeutic attention on that strand perhaps to the neglect of the other strands which may sometimes be quantitatively more important.

To turn to a more general concept, I want to read a short paragraph out of the book called "Science, Sense and Nonsense" by Synge, who is Professor of Theoretical Physics at Trinity College Publinii. Though it is difficult and painful, the difficulties and pain are due to confusion. From time to time with enormous intellectual effort, someone creates a little order, a small spot of light in the dark sea of confusion. At first we are all dazzled by the light because we are used to living in the darkness, but when we regain our senses and examine the light, we find that it comes from a farthing candle, the candle of common sense.

"The sages chase their own tails throughout the ages. A little child says: "Gentlemen, you are chasing your own tails." The sages gradually lose their angular momentum and glancing over their shoulders see what they are pursuing, but most of them cannot believe what they see and the tail-chasing does not die out until a generation is passed."

I have indicated some of the difficulties and alterations which have occurred in medicine and which are constantly occurring both in medicine and in medical people. There is no way of halting this. It can't be halted and ought not to be halted. But how can people understand each other a little better? Well, I can tell you exactly how it can be done: what it needs is a sympathetic understanding, and absence of the interdisciplinary jealousies and of personal insecurity and a study of semantics! Of course, as you see, this is either an ideal or a pious hope because the attainment of all these is next to impossible even though we attempt it.

With regard to a generation of medical men and their conditioning by their medical childhood as each generation comes along, I might quote to you the example of the word "functional." When I was a medical student "functional" meant, not morphologically apparent; that is due to some physiological or biochemical disturbance. It now means "psychogenic" or caused by mental disturbance. It has retained its philosophical point of view because it means incomprehensible in either case, depending upon the time at which it was said.

Another example of the point of view of medical men of different ages, is the story of Dr. Holmes and the poem he composed when the stethoscope was first brought back from France by younger American medical men. The poem describes this instrument, a short wooden instrument, and that the young doctor used this new kind of device a great deal too much, and, two flies got inside the tube of the stethoscope and they made a buzzing noise, and the diagnoses that he made using this new fangled device were of course very, very erroneous indeed. We now accept the stethoscope as a normal "article of diet," if I might put it that way, but you will see that the point of view changes with the medical generations.

And now, to illustrate this further I'd like to quote an anonymous poem (with apologies to Gilbert and Sullivan). This is called "The Scientific Medical." It is a parody on the "modern major general" song.

> I'm the very model of a scientific medical
> I know each nerve and artery, each ligament and pedicle.
> My knowledge has been built by evolutionary processes,
> From Galen and Hippocrates to present day Collossuses.
> I've studied all the endocrines and know the various offices,
> Of pancreas and thyroid or of thymus and hypophysis.
> I know the suprarenals, too, and all that they're related to,—Related to,—related to,—
> How benighted were the medicoes who lived in 1882.
>
> I know the pH value of ionical acidity,
> I calculate percentages with wonderful rapidity,
> And when it comes to artery or ligament or pedicle,
> You'll find I'm just the model of a scientific medical.
>
> I'm particularly expert at a Wassermann analysis,
> I hunt for protozoa in a patient with paralysis.
> The chemistry of insulin's a subject that I revel in,
> And antitoxin therapy I'm just the very devil in.
> I know the role of calcium in various forms of tetany,
> I understand trypanosomes although I've never met any.
> And I've the latest news on perineural—sympathectomy —ectomy—ectomy.—
> My knowledge often bringing in a good substantial cheque to me.
>
> I'm very good at vitamins and matters dietetical.
> I know the graphic formulae of remedies synthetical,
> And when it comes to artery or ligament or pedicle
> You'll find I'm just the model of a scientific medical.
>
> When I've acquired some knowledge about matters pharmaceutical,
> When I can diagnose a little deeper than the cuticle,
> When simple indigestion has become a trifle clear to me,
> When babies with the colic are no more a source of fear to me;
> When I can write a recipe with ordinary galenicals;
> And when I know the doses of the various arsenicals;
> When highbrow scientific lore no longer needs a missioner,
> You'll then consult me safely as a general practitioner.
>
> For my scientific knowledge though I'm always up-to-date with it,
> Has kept me back with practice and I'm just a little late with it
> But when it comes to artery or ligament or pedicle,
> You'll find I am the model of the scientific medical.

The above appeared anonymously in the Journal of Chemistry and Industry, in 1929. Nobody knows who wrote it.

It illustrates definitely what I have just pointed out. People do think other people do not have the art of medicine or the spirit of medicine, etc., and it is a continuous process. There is, then, the necessity for the desire to communicate and then the great semantic difficulties of finding the words with which to do so. Examples of difficulties of communication follow. With regard to this, John Buchan who was Lord Tweedsmuir, when Governor General of Canada, gave a speech on the use of English, and he said quite truly that our scientific specialism has now gone so far with regard to jargonization; that each group can only communicate with those immured in the same mausoleum. In the use of words, one group of people will use one word to mean one thing, another group will use it quite differently. "Stress," for example, is a dreadful word. It has been used for all sorts of things. So is "shock," and if you talk about "shock," for example to different people, you will find yourself in the same position as I am when I go to Boston. Somebody says the MGH, and I instinctively think of the Montreal General Hospital while of course it is the Massachusetts General Hospital.

It may apply to a medical student taking a case history at the bedside.

"One day while passing through the men's ward, the author observed an intensely occupied student seated beside a bed, his head bent over a pad on which he was writing vigorously. Next to his notebook lay the "Outlines of medical history." During a period of fully ten minutes, the student never raised his head to look at the patient whose story he was recording. As rapidly as possible, categorical questions ascended from his downward pointing lips, and he as rapidly wrote down the equally categorical, and often monosyllabic answers. From time to time one could see above his bent head that the patient had his tongue in his cheek and winked knowingly across the ward at some understanding crony. The deductions from this situation are obvious. The historian and his patient met as strangers and remained strangers to the end of the interview. The young doctor completely oblivious of the man in the bed, sought only to fill out a required blank which—indeed—remained a blank. The patient, equally disinterested, was annoyed and bored by the detached questioning. He, like all patients, was hoping for a physician with special understanding, not of forms and of medicine but of himself. Here, again, we see the challenge of wisdom to science."

That is a description of a student. In Montreal, we have a number of people who speak French as their mother tongue. Though this is not the place to discuss it, I feel very strongly that no one can practice medicine in the Province of Quebec unless he can understand French really well, because it is unfair to ask anyone to express themselves when they are ill, except in their mother tongue. Furthermore they cannot do it and a truly good medical history cannot be obtained.

I was going down the ward once, and there was a French Canadian man who had had a coronary thrombosis. The scientific aspects of the diagnosis were well established, but the students would not believe he had had a coronary thrombosis because he had had no pain, and so I said to him: "Qu'est-ce que c'est que vous-avez senté?" "What did you feel?" And he said: "C'etait comme si on avait une grande joie ou une grande tristesse." "It was as if one had had a great joy or a great sorrow." Now if you will remember, that angina, anguish, anger, anxiety, angst, angor, anxieté are all basic words. They come from the Aryan root word *ang* which means a strangling pain. We speak of angina, and here, then is a sound which has been used by humanity in many languages for a long period of time to express what in part this patient expressed. Here we see a reflection of an emotional situation from an organic lesion, and yet that word has been used as I say, in many languages. I think it profoundly illustrates the fact the words we use in medicine are often based more deeply than we realize.

We say "crushing" or "anguish"—we are using words which have been used for many centuries by man, to express certain rather deep feelings and sensations. We also medically—speak of angina as a sore throat. Well, the other day Dr. G. R. Brow called me in and said: Look at this electrocardiogram. Do you know this man has been to three of our Nose and Throat Specialists because he had a sore throat. He only had a sore throat when he exercised. He had *angina pectoris*. So there you have the same word again, and in that instance it is mixed up practically and scientifically, but it is related to that sensation which has been expressed in many other common non medical words.

Another great difficulty in understanding is illustrated by the story that Oliver Wendell Holmes tells in the Autocrat At The Breakfast Table of six people in a conversation. John and Tom were conversing. Now the six people were: The real John—(whatever that may be)—John's John and Tom's John and so for Tom. Now let us suppose that John is really a stupid person, thinks himself extremely brilliant, and Tom considers him an artful rogue. It's a wonder says Holmes that they understand each other at all. And that is a continuing condition and it is extremely difficult to get over and that is as true of patients as it is of one's friends, as it is of one's enemies. Still, it seems to me that this is part of the difficulty of medicine; it is part of the difficulty of communication which we have in some way to get over.

Now, another thing which makes communication difficult at scientific meetings is the insecurity of the doctor, and he is more insecure when he is in his own local place than he is when he is at a meeting outside. You know the definition of a visiting fireman is an ordinary guy far from home. Well, that is true. I must say I'm afraid it is true of local meetings in a hospital, that the fear of what Dr. Dash would say usually prevents people from talking at all, for fear of their practice being affected. To illustrate I want to read (slightly paraphrased) to you from a small book published in 1913 called "Microcosmographia Academica" by F. M. Cornford, who used to be Professor of Greek, in Cambridge, England. It is called a guide to the young academic politician, and it is applicable far outside the walls of the university or hospital:

> Let us first consider the political motive. (This is addressed to the young academic politician between the ages of 25 and 35.) You will begin, I suppose, by thinking that those people who disagree with you and oppress you, must necessarily be dishonest. Cynicism is the besetting and venal fault of declining youth and disillusionment its last illusion. It is quite a mistake to suppose real dishonesty is at all common. The number of rogues is about equal to the number of men who act honestly, and it is very small. The great majority would rather behave honestly than not. The reason why they do not give way to this natural preference of humanity is that they are afraid that others will not, and the others do not because they are afraid they will not. Thus it comes about that, while behavior which looks dishonest is fairly common, sincere dishonesty is about as rare as the courage to evoke good faith in your neighbors by showing that you trust them. No, the political motive in the academic breast is honest enough, it is fear, genuine, perpetual, heartfelt timorousness, and we shall see presently that all the political arguments are addresses to this passion. Have you ever noticed how many people say "I'm afraid I don't" when they mean "I think I don't." The proper objects of fear, hereafter to be called "bugbears," are in order of importance: "Giving yourself away, females, what Dr. Dash will say, the public washing of linen, the great world outside."

Pornforo's Political Parties I think are interesting. You remember this was written in 1913. He writes: "But first I'd better describe the parties, in academic politics and it is not easy to distinguish them precisely. There are five and they are called Conservative Liberals, Liberal Conservatives, Nonplacets, Adulamites, and Young Men in a Hurry. A Conservative-Liberal is a broadminded man who thinks that something ought to be done, only not anything that anyone now desires but something which was not done in 1881. A Liberal-Conservative is a broadminded man who thinks that something ought to be done, only not anything that anyone now desires and that most things which were done in 1881 ought to be undone. The men of both these parties are alike in being open to conviction, but so many convictions have already got inside that it is very difficult to find the openings; they dwell in the valley of indecision.

The Nonplacet differs from these in not being open to conviction; he is a man of principle. A principle is a rule of an action which states a valid general reason for not doing in any particular case what to unprincipled instinct would appear to be right. (The Nonplacets believe that it is always well to be on the safe side which can easily be located on the "no side" of any question.)

The Adulamites are dangerous because they know what they want, e.g. all the money there is going. They inhabit a series of caves near Downing Street. They say to one another: "If you'll scratch my back, I'll scratch yours. If you won't, I'll scratch your face."

The Young-Man-In-A-Hurry is a narrow-minded and ridiculously youthful prig who is inexperienced enough to imagine that something might be done before very long and even to suggest very definite things. His most dangerous effect being want of experience; everything should be done to prevent him from taking part in affairs. He may be known by his propensity to organize societies for the purpose of making silk purses out of sow's ears. This tendency is not so dangerous as it might seem, for it may be observed that the sows, after taking their washing with a grunt or two can go back unharmed to the wallow and the purse market is reported as firm.

So that illustrates some of the difficulties of understanding communication and organization in medicine. Actually this all sounds so difficult one would think nothing can be done about it. I still think that a great deal can be done about it by sympathetic understanding and by some form of modification of the ideal which I enunciated. I would like for your comfort to end by quoting a poem which, I believe, was composed by Alec Templeton, and is entitled, "Friendship":

> Oh the comfort
> The inexpressible comfort of feeling safe with a person
> Having neither to weigh thoughts nor measure words,
> But, putting them all out just as they are
> Chaff and grain together

Certain that a faithful hand
Will take them and sift them
Keep what is worth keeping, and with a breath of kindness
Blow the rest away.

And that, ladies and gentlemen, is the spirit of Medicine.

Dr. Pincoffs: Dr. Browne, I think the audience has shown its immediate appreciation of what you have said. I have the pleasure of presenting to you the Ridgeway Trimble Medal as a memento of this occasion.

And this, Ladies and Gentlemen, brings us to the end of this session of the Medical and Chirurgical Faculty.

* * * * *

GAMMA GLOBULIN FOR MEASLES AND HEPATITIS

Source From National Foundation for Infantile Paralysis

Recently, the National Foundation for Infantile Paralysis completed negotiations for the purchase of the present inventory of certain processors of commercial gamma globulin as well as the future production by these same producers. In agreement with the American National Red Cross all gamma globulin processed from Red Cross donated blood, as well as the commercially produced gamma globulin purchased by the National Foundation, has been placed under control of the Office of Defense Mobilization. The National Foundation does not have in its possession or control any supply of the blood fraction.

It has been agreed by all parties concerned that gamma globulin will be available for measles prophylaxis and for use by physicians in the treatment of infectious hepatitis, irrespective of the resulting limitation of gamma globulin available for use in poliomyelitis epidemics.

The Office of Defense Mobilization will allocate the available gamma globulin through State and Territorial Health Officers for use in measles and infectious hepatitis, and will make additional distribution for the purpose of controlling poliomyelitis.

Physicians who are unable to purchase gamma globulin through their regular drug supply channels are advised to request supplies from their local or state health departments. There will be no charge for this gamma globulin, since the Red Cross has already paid for the processing and packaging of the material, and the National Foundation for Infantile Paralysis, through its arrangement with the commercial processors, has purchased the commercial supply at the same rate as that currently supplied defense agencies under governmental contract.

The National Foundation does not have gamma globulin available for distribution, nor will it determine how available supplies shall be used. That is the function of the Office of Defense Mobilization.

Since it has been obvious for some year and a half that gamma globulin would be in short supply, the above plan was agreed upon by all interested agencies, governmental, private and public, to avoid wasteful use of gamma globulin.

* * * * *

PHYSICIANS NEEDED TO CONDUCT PHYSICAL EXAMINATIONS OF INDUCTEES

The Armed Forces Examining Station, 112 South Gay Street is desirous of obtaining the services of physicians to conduct physical examinations of inductees. The duty would require 2 to 3 hours daily and the rate of pay is $25.00 per day. The station would like to have a list of physicians on whom they may call, the requirements depending entirely on the flow of inductees. General practitioners are desired, but there will be occasional calls for specialists for consultation. It would be possible to give seven to fourteen days notice when the services of a physician are required.

Any physicians interested in this duty should apply to Major R. M. Flynn, Armed Forces Induction Station, 112–114 South Gay Street, Baltimore 2, Maryland.

Scientific Papers

Seminar: Recent Advances in Radiological Studies of the Vascular System[*]

AORTOGRAPHY

E. CONVERSE PEIRCE, 2ND, M.D.[†]

INTRODUCTION

Dr. Dotter, members of the panel, ladies and gentlemen:

It is a great privilege to be here this evening to take part in the discussion of arteriography and angiocardiography. With the permission of the chairman, I have taken the liberty of discussing aortography primarily, by which I mean the contrast visualization of the aorta and its major branches, rather than peripheral arteriography.

Peripheral arteriography was reported first in 1923 in France and Germany and a year later independently by Brooks in this country (1). It is now an established procedure, the technique for which is quite simple. An 18 gauge needle may be inserted into the femoral artery just below the inguinal ligament. Immediately following the injection of 10 cc. of concentrated contrast material two exposures are taken at 5 to 6 second intervals to show the upper and lower levels of the lower extremity. A similar technique is used for the upper extremity and a somewhat longer delay is necessary if pictures of the hands or feet are desired.

By injecting through a larger needle against the blood current it is possible to make satisfactory pictures of vessels as high as the bifurcation of the aorta (2). This, however, is considerably more difficult than making pictures by injecting dye at a higher level as I will explain.

Peripheral arteriography is not much used at the present time because it does not ordinarily provide a diagnosis of the usually quite obvious arterial block. For example it is not usually possible with arteriography to distinguish Buerger's disease from arteriosclerosis obliterans. The principal use of the method is in the evaluation of lesions that can be corrected by surgery such as peripheral aneurysms, arteriovenous fistulas, and femoral arterial blocks that are susceptible of reconstructive surgery. I believe that any of you who find the need for making peripheral arteriograms should feel no hesitation in carrying out the procedure as it is both simple and benign.

With the rapid advances in new surgical methods for treating diseases of the aorta and its larger branches there has been the need for increased use of contrast studies of these structures. In addition aortography has been found useful in the differential diagnosis of renal, adrenal, and retroperitoneal masses, to mention only a few examples. The technique may conveniently be divided into thoracic and abdominal and several methods are available for each.

---

[*] Presented before the Baltimore City Medical Society on Friday, March 20, 1953, Osler Hall, Medical and Chirurgical Faculty of the State of Maryland Building, 1211 Cathedral Street, Baltimore 1, Maryland.

[†] National Health Institute (Resident in Surgery, U. S. Public Health Service Hospital, Baltimore).

Abdominal aortography is particularly useful in the evaluation of obscure renal diseases and has been utilized for such diverse purposes as the evaluation of tuberculosis prior to segmental renal resection (16), the differential diagnosis of cysts and neoplasms, and the diagnosis of aberrant vessels (3, 7). Aortography has been used with great success in a few instances in the localization of adrenal tumors such as pheochromocytoma and cortical adenoma (fig. 1) (6). Retroperitoneal masses frequently cannot be evaluated by the usual methods. The use of aortography with and without retropneumoperitoneum has improved the accuracy of our evaluation (12). The most important use, however, of aortography centers in the diagnosis and minute evaluation of arterial diseases susceptible of surgery including aneurysms, arteriovenous fistulas, and occlusive diseases of the aorta or iliac arteries (fig. 2) (10).

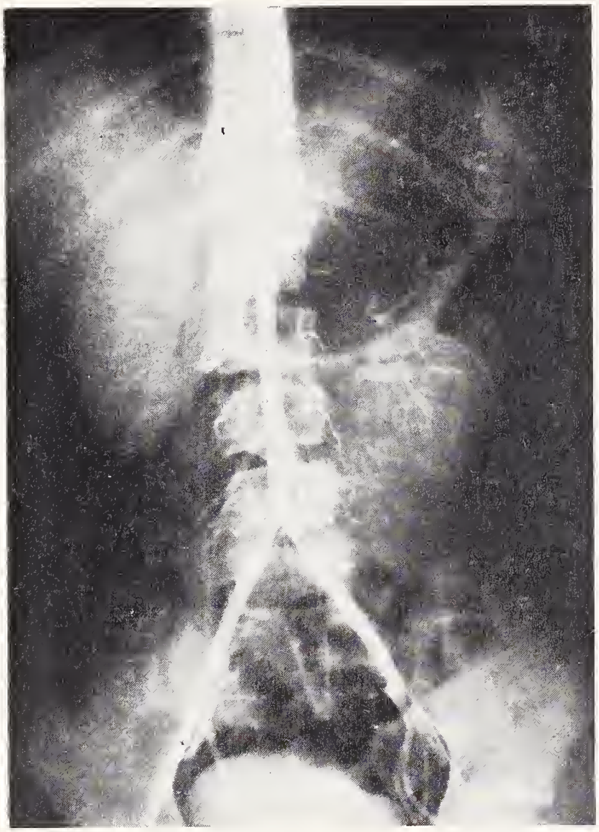


Fig. 1. A four year-old white male with a small left flank mass and precocious sexual development. The aortogram shows an irregular area of increased vascularity above the upper pole of the left kidney which is displaced downward and rotated laterally. At surgery a cortical tumor 7 cm. in diameter was removed through a thoraco lumbar incision. Catheter passed after femoral artery "cut-down," Harriet Lane Home.

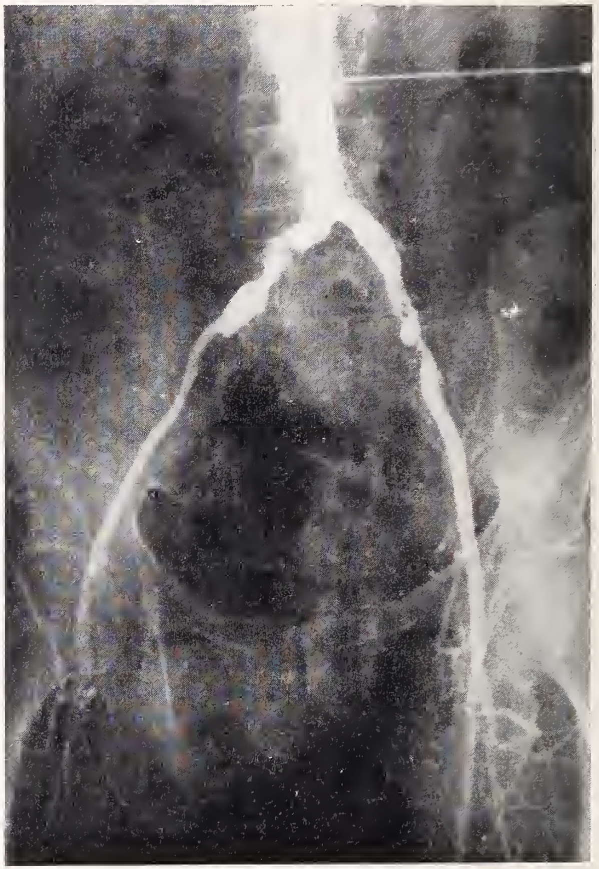


Fig. 2. A 49 year-old white male who had had an endarterectomy in the left iliac region 2 years before for complete occlusion. A low thigh amputation had been necessary on the right following an acute arterial occlusion. There are marked arteriosclerotic changes in the aorta and iliacs. Vascularity is greater on the left. Translumbar arteriogram.

Thoracic aortography is much less widely used but is perhaps even more valuable than abdominal aortography. It is particularly useful in certain complicated forms of congenital heart disease, especially patent ductus arteriosus with atypical murmurs, and coarctation of the aorta, presenting unusual clinical features (fig. 3), which may be either in an atypical location or because of its length require the use of an arterial graft for repair (8). The method also shows promise of value in other conditions including congenital aortic and subaortic stenosis (fig. 4) and various types of arch malformation. The most common need, however, for thoracic aortography is in the differential diagnosis of aneurysm and neoplasm, and when aneurysm proves to be the disease at hand, the method is invaluable in enabling one to determine whether surgery is feasible and if so how it should be carried out (fig. 5).

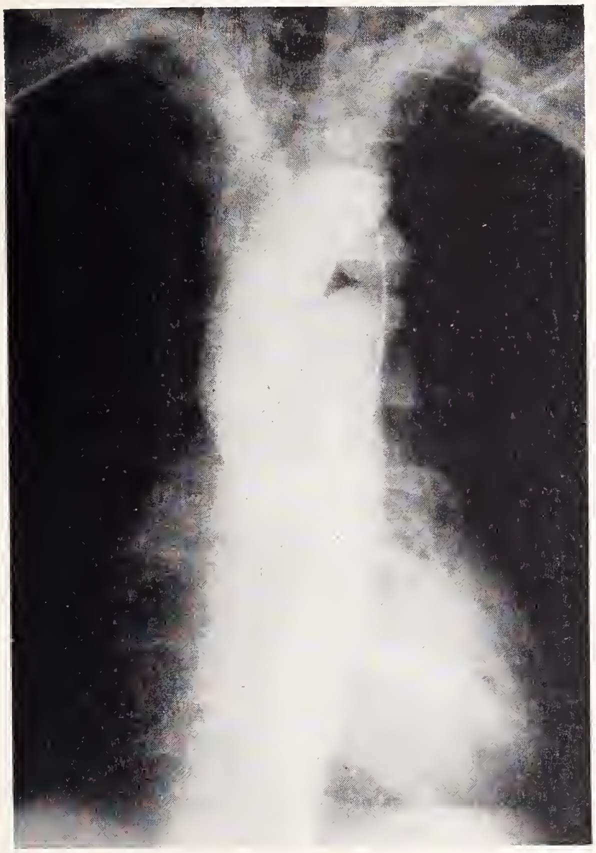


FIG. 3. Coarctation of the aorta in a 40 year-old male. Blood pressures were equal in the upper and lower extremities; there was no rib notching. The patient suffered from episodic hypertension and paroxysmal auricular tachycardia. Percutaneous femoral aortogram shows classical deformity of distal arch and coarctation. Demonstration of the upper segment cannot be relied on by this method.

I will briefly outline the main features of the principal methods of aortography and show examples in the various groups of conditions. There is generally more than one way to show a lesion in a particular location. The methods, however, differ considerably in difficulty, area of application, and quality of the final aortogram and it is necessary to know them all so that the proper one may be chosen in the more complicated cases. Abdominal aortography may be undertaken without great preparation. It is a procedure that is not particularly upsetting to the patient and it is without great risk. Thoracic aortography, however, should not be undertaken lightly as it is relatively difficult and entails the ever possible result of hemiplegia or other serious brain damage (11).

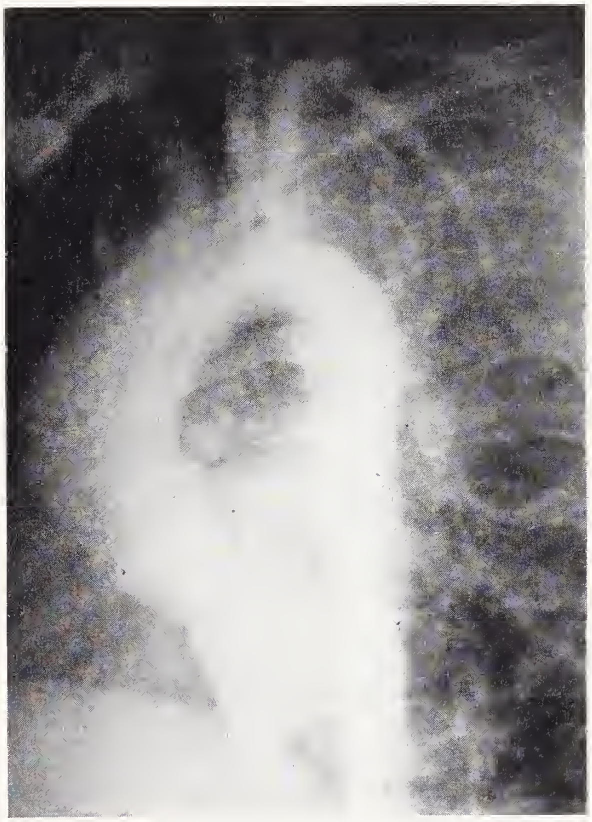


FIG. 4. Probable subaortic stenosis in a 10 year-old child with breathlessness on effort and an extremely loud aortic systolic murmur and thrill. The ascending aorta is very wide and bowed and there is probable subaortic deformity. Angiocardiogram.

TRANSLUMBAR AORTOGRAPHY

Aortography of the abdomen was introduced by Dos Santos and his collaborators in 1929 (4). A large needle is directly inserted into the upper abdominal aorta through the lumbar region. This translumbar method may now be considered a standard procedure. There have been many thousands of satisfactory examinations with only a few mishaps. It is a good method for all abdominal problems and is probably the easiest of all of the aortographic methods (fig. 2) (3, 7).

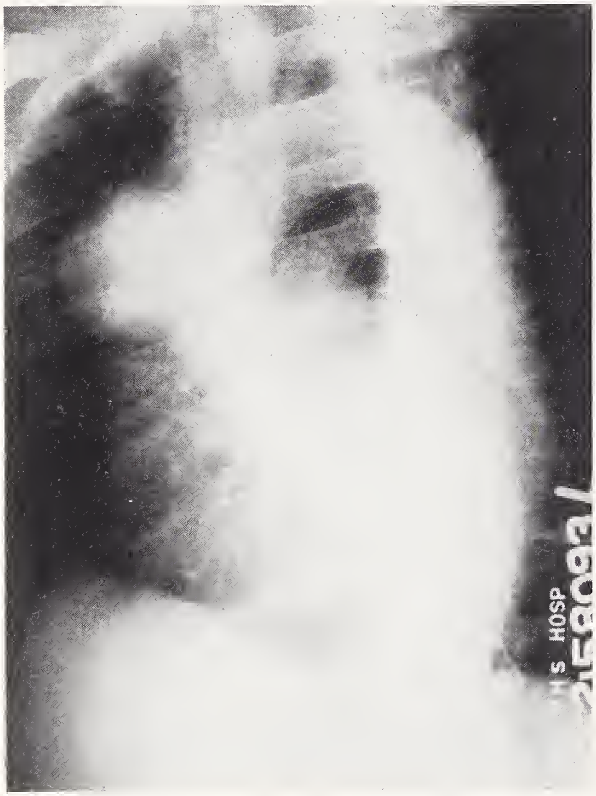


FIG. 5. Syphilitic aneurysm of the ascending aorta in a 47 year-old colored male successfully resected by Dr. Henry Bahnson. Angiocardiogram.

As generally practiced the method is essentially limited to the examination of the abdomen. Placement of the patient is somewhat difficult and it is not always possible to inject the contrast medium in the exact spot desired. Because extravasation of dye occurs occasionally and is extremely painful it is advisable in some patients to use general anesthesia. The method has been used in children but because of difficulty in locating the aorta it is generally not considered very satisfactory.

ANGIOCARDIOGRAPHY

Angiocardiography, which consists of injecting rapidly a large volume of dye into a vein and following it with serial films during its passage through the heart and great vessels, was introduced in 1939 by Robb and Steinberg (15). This procedure has been of outstanding value primarily for the diagnosis of cardiopulmonary diseases but it also constitutes the easiest method of thoracic aortography (5). It will generally permit satisfactory visualization of the ascending aorta and arch (figs. 4, 5), frequently produces films of diagnostic quality for the descending aorta, and is even rarely useful for the abdomen. It also provides additional useful information in many cases by its passage through the heart and lung.

The equipment for angiocardiography is relatively complicated. Careful timing and serial films are necessary. Unfortunately films of the aorta are generally poorer in quality than those obtained by direct aortography.

CATHETERIZATION VIA THE BRACHIAL ARTERY

Following the work of Farinas, Radner of Sweden in 1948 described thoracic aortograms of excellent quality obtained by passing a catheter from an artery in the arm into the ascending aorta and injecting dye under pressure (14). This method will produce very satisfactory films of the thoracic aorta in most instances. It is probably the most satisfactory technique for coarctation since angiocardiography frequently produces films too poor in quality, and aortograms made from below the narrowed segment may fail to outline the aorta above the constriction (8).

This method requires an arterial cutdown and it is not always possible to pass the catheter into the aorta. It is technically quite difficult and although it is not considered important, it is generally necessary to sacrifice the radial artery. Using a common radiopaque cardiac catheter it is generally necessary to utilize some type of pressure device to insure rapid enough injection of dye. The method is practically speaking limited to the thorax and entails the usual danger of cerebral reaction to contrast medium.

PERCUTANEOUS FEMORAL CATHETER AORTOGRAPHY

This method was developed in dogs at the Children's Hospital in Boston and in humans at the Marine Hospital here in Baltimore (10, 12, 13). The procedure is carried out under local anesthesia by inserting a large needle into the femoral artery and passing through it a fairly large bore polyethylene catheter. The catheter tip may be located anywhere from the point of insertion to the aortic valve and good aortograms have been obtained in any portion of the aorta (fig. 3). This has proved to be the most accurate of the abdominal methods and the most versatile of the thoracic methods. Relatively small volumes of contrast material are required. The patient may be positioned as desired and films are obtainable at more than one level. The method has been used successfully in children as young as 2 years.

The major disadvantage is that the method is more difficult and time consuming than translumbar arteriography or angiocardiography. Rarely it is not possible to pass the catheter. It shares with other methods of thoracic aortography the danger of cerebral reaction to contrast medium and should probably not be used in severe occlusive disease of the iliac or femoral artery.

In occasional cases, generally children, in whom percutaneous insertion of the catheter proves too difficult, a femoral arterial cutdown can be utilized. There is probably a real danger of vascular occlusion when this is done, however, and the risk should be carefully weighed before undertaking the procedure (fig. 1).

COUNTER CURRENT AORTOGRAPHY VIA THE BRACHIAL ARTERY

Although catheter aortography, angiocardiography and translumbar arteriography can be utilized in children in the few instances where information is really needed they are probably not suitable in infants. The method of Keith and Forsyth described in 1950, whereby a small volume of dilute contrast material (3–6 cc.) is injected in retrograde fashion up the left brachial artery into the aorta, will probably give satisfactory aortographic pictures in infants (9). The ascending aorta and arch are frequently not filled. A rapid changer is desirable and somewhat limits the usefulness of the method (fig. 6).

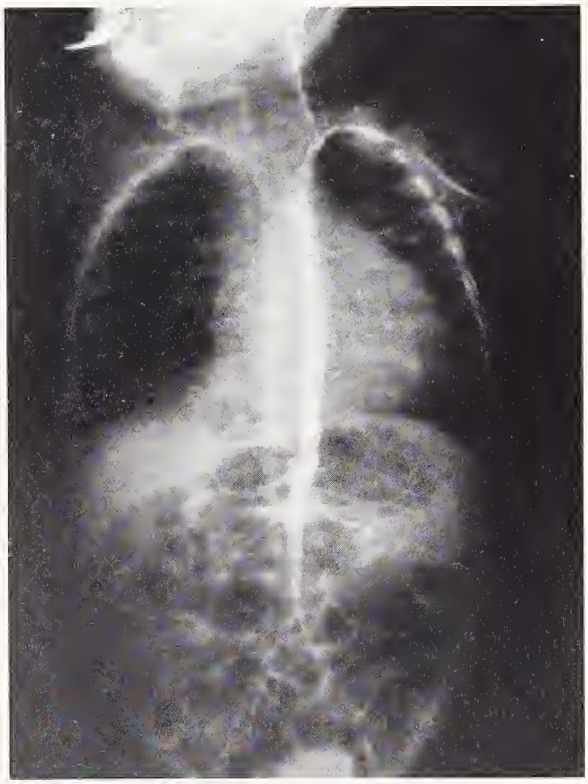


FIG. 6. Normal aortogram ruling out patent ductus arteriosus in infant with severe heart disease requiring use of oxygen tent. Method of Keith and Forsyth. Baltimore City Hospitals.

OTHER METHODS

A number of other types of aortography and minor modifications of the types mentioned have been described. These are useful in specific instances only.

SUMMARY

Peripheral arteriography is a relatively simple procedure of limited usefulness. Abdominal aortography is a somewhat more difficult procedure with numerous applications. It can readily be learned by almost anyone. Thoracic aortography is a procedure requiring considerably more skill and involving an appreciable risk. Its use, however, is essential in the proper management of the more complicated thoracic vascular diseases and it should be practiced in all centers dealing with these conditions.

BIBLIOGRAPHY

1. Brooks, B. Intra-arterial injection of sodium iodid; preliminary report. J.A.M.A. **82:** 1016–1019, 1924.
2. Castellanos, A., and Pereiras, R. Counter-current aortography. Rev. cubana cardiol., **2:** 187–205, 1940.
3. Deterling, R. A. Direct and retrograde aortography. Surgery, **31:** 88–114, 1952.
4. Dos Santos, R., Lamas, A., and Pereira Caldas, J. L'artériography des membres de l'aorte et ses branchés abdominales. Bull. Soc. nat. chir., Par., **55:** 587–601, 1929.
5. Dotter, C. T., and Steinberg, I.: Angiocardiography. Annals of Roentgenology, Vol. XX., Paul B. Hoeber, Inc., New York, 1951.
6. Goodwin, W. E., Moore, V., and Peirce, E. C., 2nd. Aortography and retropneumoperitoneum in evaluation of adrenal lesions. Submitted for publication.
7. Goodwin, W. E., Scardino, P. L. and Scott, W. W. Translumbar aortic puncture and retrograde catheterization of the aorta in aortography and renal arteriography. Ann. Surg. **132:** 944–958, 1950.
8. Jönsson, G., Broden, B., and Karnell, J. Thoracic Aortography: With Special Reference to its Value in Patent Ductus Arteriosus and Coarctation of the Aorta. Acta. Radiol. Supp. **89:** 1951.
9. Keith, J. D., and Forsyth, C. Aortography in infants. Circulation, **2:** 907–914, 1950.
10. Peirce, E. C., 2nd. Percutaneous femoral catheterization in man with special reference to aortography. Surg. Gynec. and Obst., **93:** 56–74, 1951.
11. Peirce, E. C., 2nd. Temporary hemiplegia from cerebral injection of diodrast during catheter aortography. Report of two cases. Circulation **7:** 385–392, 1953.
12. Peirce, E. C., 2nd. Percutaneous femoral artery aortography: its use in the evaluation of retroperitoneal masses. J. Internat. Coll. Surgeons **20:** 16–28, 1953.
13. Peirce, E. C., 2nd., and Ramey, W. P. Renal arteriography: Report of a percutaneous method using the femoral artery approach and a disposable catheter. J. Urol., **69:** 578–585, 1953.
14. Radner, S.: Thoracal aortography by catheterization from radial artery; preliminary report of a new technique. Acta radiol. **29:** 178–180, 1948.
15. Robb, G. P. and Steinberg, I. Visualization of the chambers of the heart, the pulmonary circulation, and the great blood vessels in man; a practical method. Am. J. Roentg., **41:** 1–17, 1939.
16. Weyde, R. Abdominal aortography in kidney tuberculosis; preliminary report. Journal Oslo City Hospitals **1:** 269–277, 1951.

ANGIOCARDIOGRAPHY

CHARLES T. DOTTER, M.D.* AND ISRAEL STEINBERG, M.D.†

Angiocardiography is the contrast roentgenographic study of the heart and great thoracic blood vessels during their opacification by an intravenously injected radio-opaque solution. The technique as it is performed today was perfected by Doctors George P. Robb and Israel Steinberg, in 1937.

The angiocardiographic injection to be successful must be rapid. In practice the full dose of opaque substance (40–50 cc. in an adult) is injected in the total time of 1.5 seconds. Radiographic study of the chest is then made at appropriate or multiple intervals during the passage of the opaque medium through the mediastinal veins, the right heart chambers, the pulmonary circulation, the left heart chambers, and the aorta. In the normal individual approximately ten seconds are required for this cycle to take place.

Angiocardiography produces an unpleasant immediate side reaction consisting of a hot flush, weakness, occasional nausea, and rarely syncope. The subjective reaction is probably least when Urokon is the contrast substance employed.

---

* University of Oregon Medical School, Portland, Oregon.

† Cornell University Medical School, New York, New York.

In 50 to 75 per cent of cases, a sterile thrombus forms within the injected vein. In our experience these have not given rise to emboli. Although angiocardiography has resulted in a number of deaths—mostly occurring in young patients with congenital heart disease—we have performed two thousand examinations without a fatality. In children the technique should be reserved for cases wherein the findings may be expected to modify the plan of therapy. Its use in the adult for academic purposes is probably justified. The technique of examination is exacting although not difficult. Angiocardiography is a radiologic procedure and should be conducted in the Radiology Department.

Applications of Angiocardiography

The procedure has proved itself to be of great value in the study of many forms of cardiac, pulmonary and mediastinal disease. Its application to congenital heart disease is well-known and exemplified by coarctation of the aorta and the tetralogy of Fallot. In coarctation, the angiocardiogram can be expected to show the site and nature of the narrowing. This information is of value in planning surgery. It is our belief that angiocardiography (or some other method of contrast study of the aorta) should constitute a routine pre-operative measure in all cases of coarctation of the aorta. It should not be reserved for the "special cases" since physical examination does not allow the examiner to determine which case is a "special case." The physical findings caused by a coarctation low in the thoracic aorta and involving a long narrow segment of the vessel would be identical with those caused by the usual lesion. Figure 1 illustrates the appearance of the latter in a patient who was later successfully operated upon.

It is sometimes necessary to employ additional techniques such as those Dr. Peirce has discussed. Figure 2 illustrates a retrograde abdominal aortogram made in a young girl with coarctation of the abdominal aorta. The angiocardiogram demonstrated the location of the coarctation but was insufficient to outline the detailed vascular relationship.

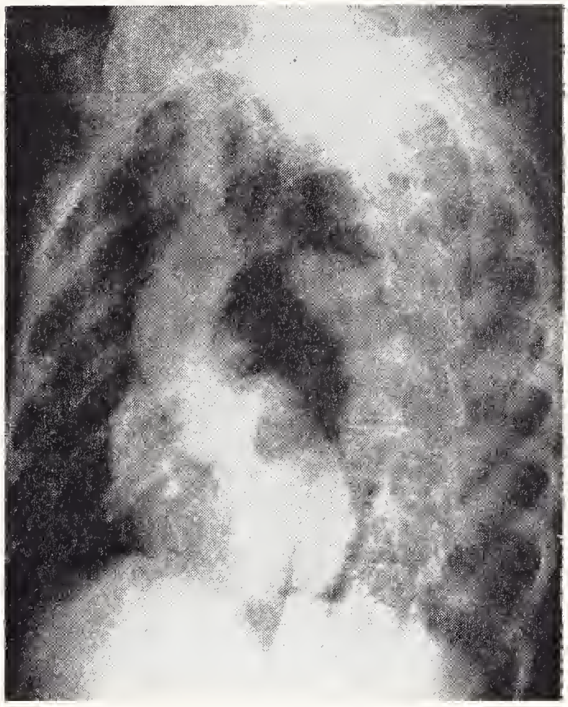


Fig. 1A

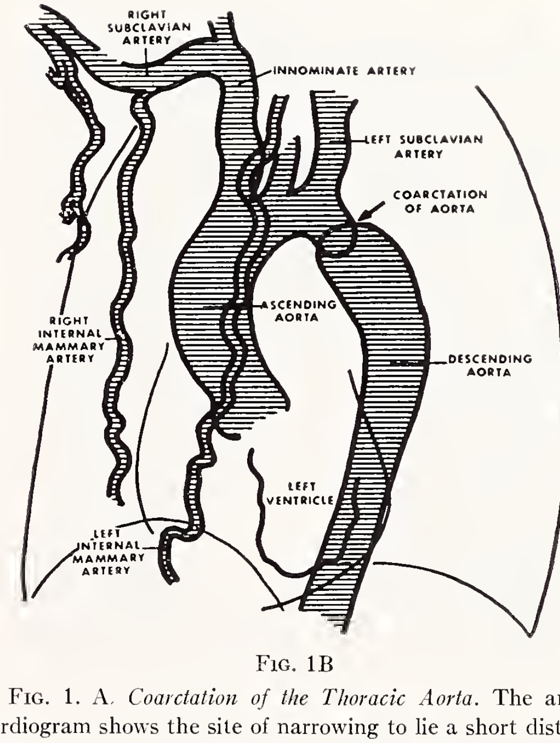


Fig. 1B

Fig. 1. A. *Coarctation of the Thoracic Aorta.* The angiocardiogram shows the site of narrowing to lie a short distance distal to the origin of the left subclavian artery. B. Tracing of A.

In the tetralogy of Fallot and other cyanotic

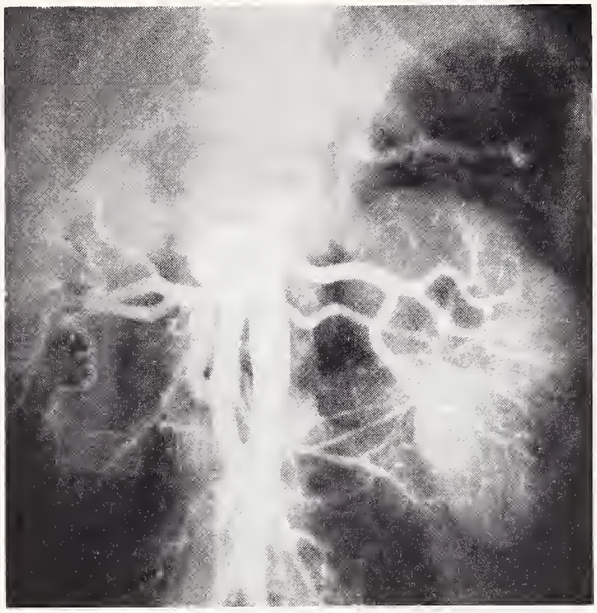


Fig. 2. *Coarctation of Abdominal Aorta.* Retrograde abdominal aortography shows the lower part of an atypical coarctation of the abdominal aorta. Branches of the aorta distal to the coarctation are visualized as is a small aneurysm of the right renal artery.

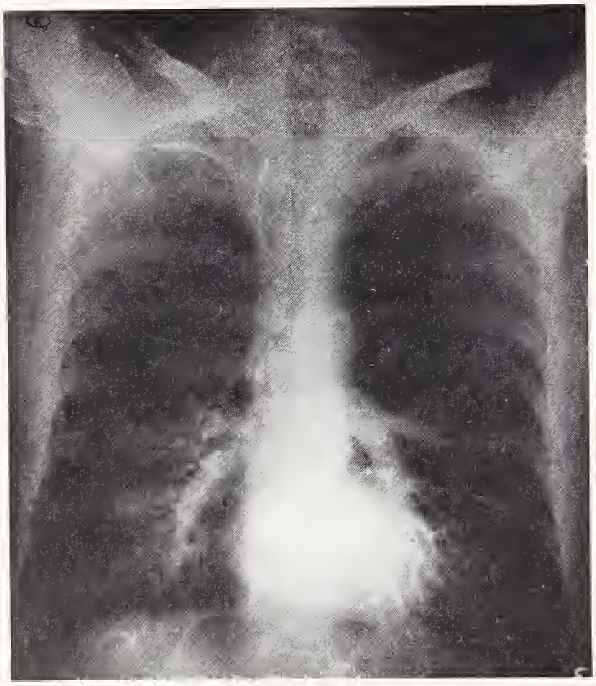


Fig. 3. *Bullous Emphysema.* Emphysematous bullae have compressed the pulmonary arteries into the basal areas. The vessels are otherwise normal.

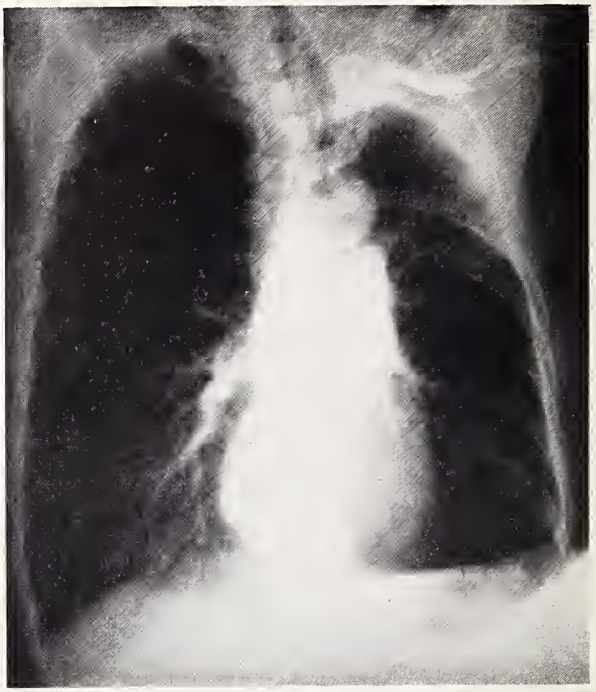


Fig. 4. *Bullous Emphysema, Post Operative.* Following resection of the left upper lobe the vessels to the remaining re-expanded left lower lobe have assumed a more normal appearance. The patient was greatly improved following surgery.

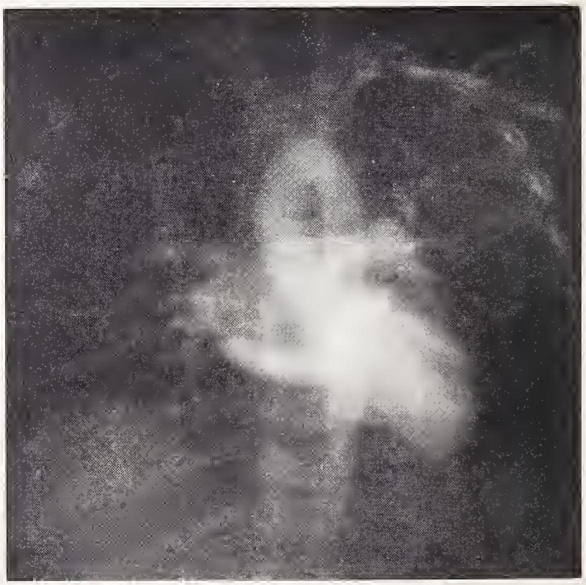


Fig. 5. *Myxoma of the Left Atrium.* A polypoid filling defect caused by the tumor deforms the contrast substance within the left atrium.

congenital cardiac lesions, the physiological abnormality is such as to facilitate examination by angiocardiography. Right-left shunts show up well, the site of shunt representing the origin of the cyanosis. Pulmonary stenosis can frequently be demonstrated either directly or indirectly. We believe that angiocardiography should constitute a routine procedure in the pre-operative study of patients with cyanotic congenital heart disease.

Carcinoma of the lung frequently produces gross distortion of major pulmonary and mediastinal vessels which cannot be detected by conventional methods of physical examination or roentgen study. Angiocardiography is ideally suited to reveal these changes and therefore contribute to an understanding of the pathologic process present. In approximately 25 per cent of cases studied, angiocardiography will reveal a diagnosis of inoperability and can in some instances obviate need for painful, unproductive surgery. We have studied more than one hundred and fifty proved cases of carcinoma of the lung by means of angiocardiography and feel that this method of examination is of particular value when there is evidence to suggest hilar or mediastinal spread of the neoplasm. Unfortunately, opacification of the pulmonary arteries does very little to aid in the differential diagnosis of round pulmonary parenchymal lesions.

An interesting application of the technique lies in the visualization of distorted pulmonary vessels associated with localized or bullous emphysema. Figure 3 illustrates bilateral upper lobe localized emphysema in a patient who was physically incapacitated due to respiratory insufficiency. Following resection of the cyst of the left upper lobe by Dr. Laurence Miscall, the patient was for the first time in two years able to return to his occupation. The post-operative appearance in this instance is shown in Figure 4, the vascular supply of the remaining left lung having spread out to assume a more normal appearance.

In rheumatic heart disease angiocardiography has provided information of considerable academic value. For example, it has demonstrated that the characteristic changes in *early* mitral stenosis are due almost entirely to enlargement of the left atrium. Where formerly it was believed that enlargement of the right ventricle caused obliteration of the retrosternal space, contrast visualization has shown that this is due to displacement of the right ventricle by an enlarged left atrium. Angiocardiography has shown that the pulmonary conus does not reach the left heart border in frontal projection. It has demonstrated a regurgitant jet deforming opaque substance within the right atrium in patients with tricuspid insufficiency. It has demonstrated thrombi in the left atrium in patients with rheumatic mitral stenosis. Possibly the technique will prove to be of value in the physiologic and anatomic study of patients before and after mitral surgery.

Perhaps the most striking angiocardiographic study in our files is represented by Figure 5. This angiocardiogram—a left heart film—shows an ovoid, irregular filling defect in the mid-portion of the left atrium in a three year old child. The mass proved to be an intra-atrial myxoma. We have seen two other cases such as this and in all three cases the pre-operative or pre-mortem diagnosis of intra-cardiac myxoma was correctly made.

It has not been our intention tonight to attempt to cover the field completely. The different techniques about which you have heard include angiocardiography, cerebral angiography (as presented by Dr. Chambers), and aortography (as presented by Dr. Peirce). These techniques have considerably expanded the field of diagnostic radiology in the study of cardiovascular lesions. It has been a pleasure for the members of this panel to meet with you here in Baltimore and we encourage any of you to ask us questions.

CYSTIC FIBROSIS OF THE PANCREAS*

GORDON E. GIBBS, Ph.D., M.D.†

Clinical Manifestations

The main symptoms of cystic fibrosis of the pancreas are chronic cough and mild diarrhea. Since the clinical findings also occur in more common conditions, this diagnosis is frequently overlooked. In the newborn period, the disease may appear as intestinal obstruction in one of the forms of meconium ileus. When the onset is later, the initial symptom may be digestive or respiratory. The digestive deficiency is manifested by poor weight gain; foul, bulky, soft stools (steatorrhea); wasted musculature; increased appetite; and enlargement of the abdomen. The respiratory component progresses to bronchiectasis, bronchopneumonia, and death. Even at autopsy, the diagnosis is frequently missed. The pancreas may appear grossly normal, the marked pathological changes being definite only in microscopic sections. Most cases become manifest in infancy.

Etiology

The fundamental pathogenesis of the disease remains to be elucidated. A prominent theory is that a defect of mucin metabolism exists, whereby, small tubules, particularly of the pancreas and lungs, become obstructed with mucoid materials. The abnormality could be:

1. an abnormal structure of the mucin
2. a deficiency in the liquefying mechanism
3. abnormal autonomic control of mucin secretion

The general mucin hypothesis is supported by the viscosity of the duodenal aspirate and by the engorgement of bronchial, duodenal and other mucous glands. The name "mucoviscidosis" has been proposed for this disease.[1] A similarity of the bronchial mucous glands to those seen in asthma has been considered to detract from the "mucoviscidosis" hypothesis.[2] Moreover, the increased viscosity of the duodenal aspirate (containing mucus from Brunner's glands, etc.) would seem at least partially accounted for by absence of the water and trypsin normally contributed by the pancreas.

In an attempt to find further evidence of a primary defect of mucin metabolism, studies of serum beta glucuronidase and of serum mucoprotein are nearing completion at the University of Maryland. These studies have failed to reveal any significant abnormality in concentrations of these particular substances. Further explorations of other aspects of metabolism of mucopolysaccharide derivatives are in progress.

The metaplasia of bronchial mucosa may be secondary to chronic infection, but also simulates the effects of vitamin A deficiency, giving rise to suspicion that lack of this vitamin might be involved in the primary etiology. While attempts at therapy and prophylaxis with vitamin A have been disappointing, there is no doubt that clinical vitamin A deficiency has often occurred secondarily in cystic fibrosis of the pancreas, particularly before the days of liberal vitamin A supplementation. The possibility that some other nutritional factor might be of specific etiological importance, of course, remains.[2]

Simple Office Tests

The typical case shows excess fat in the stools observed microscopically with Sudan III. This test may fail to show excess fat if the diet is low in fat or if the pancreatic deficiency is incomplete. On the other hand, conditions such as celiac disease and intestinal allergy may also give steatorrhea.

Another simple test of pancreatic function is the proteolytic action of a fecal suspension on the gelation of x-ray film.[3] Various more elaborate procedures for this test are in use, but the following specifications are designed to be so simple as to be performed conveniently by any physician with a minimum of equipment. A 1:10 suspension of stool in tap water is left on a piece of x-ray film for 90 minutes at room temperature. The suspension is then washed off with a stream of cold water. After drying, the translucency of the area is noted. This test may be confused by:

---

* Presented at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, Wednesday Morning, April 29, 1953, Osler Hall, Baltimore, Maryland.

† Associate Professor of Clinical Research, Department of Pediatrics, University of Maryland School of Medicine.

1. use of stale stool
2. incomplete pancreatic deficiency
3. unreactive type of x-ray film
4. transient pancreatic deficiency associated with other conditions
5. bacterial proteolytic enzymes[4]

The latter difficulty is most likely to occur if the patient has been on vigorous antibiotic therapy. When the hazards of interpretation are kept in mind, these simple tests have a degree of usefulness. However, a definite diagnosis of cystic fibrosis of the pancreas is rarely, if ever, justified without a satisfactorily conducted duodenal drainage.

DIAGNOSTIC HOSPITAL PROCEDURES

The most reliable diagnostic data come from duodenal drainage. While use of a single lumen tube often gives conclusive results, use of a double lumen tube for simultaneous gastric and duodenal aspiration has been found advantageous in several pediatric centers.[5, 6, 7] Use of the two single tubes has also been found practical.[5b, 8] Simultaneous gastric and duodenal drainage help to minimize contamination of the duodenal specimen by gastric fluid, a difficulty which has been very troublesome when duodenal drainage alone has been done.

The double lumen gastroduodenal tube previously described by the present writer was of 12 French diameter.[5] Recently, a larger, 14 French, tube has been used. (The tubing used in a 14F Miller-Abbot tube is satisfactory.) This tube largely avoids the difficulty of plugging which was sometimes troublesome in the smaller tube. It seems to pass the pylorus approximately as readily. A solid gold tip of the same diameter as the tubes and weighing 3.5 gm. has been used. This tip permits the tube to be passed nasally, as is convenient in older infants with teeth. A rubber bag (finger cot or Cantor tip) with 10 to 15 grams of mercury has also been used with consistent success. The bag is less convenient to pass through the nose. The value of weighting of the tip is a subject of dispute awaiting collection of additional quantitative data.

Fluoroscopic verification of the position of the tube is desirable. However, when alkaline, clear, yellow fluid comes consistently from the duodenal tube, while colorless, turbid, acetic fluid comes from the gastric, there can be little doubt of the correct position of the tube. Testing the duodenal aspirate for trypsin by means of x-ray film often gives information regarding the position of the tube. Normal juice produces partial clearing in 5 to 15 minutes at room temperature.

For evaluation of pancreatic function, the volume, alkalinity and enzyme content of the juice are useful. Stimulation of the pancreas by the hormone secretin[5a, 9] increases the significance of the volume and alkalinity determinations. Trypsin is the pancreatic enzyme most useful in the infant, amylase levels normally being low during the first few months. In our laboratory, trypsin is measured by the Anson method, which determines, colorimetrically, the tyrosine liberated from a hemoglobin substrate. Most clinical laboratories use other chemical procedures for trypsin estimations. At least one laboratory determines the viscosity of the duodenal aspirate.[10]

Tests involving digestion of vitamin A ester[11] or of protein[12, 13] have been useful in various laboratories.

INCOMPLETE PANCREATIC DEFICIENCY

Diagnosis of the disease is rendered difficult in some instances by lack of completeness of the pancreatic deficiency.[14] In such cases, the pulmonary component of the disease may be of full severity. The most refined technique of duodenal drainage is needed for attempts to establish the diagnosis in such cases. Even such technique may be indecisive at times.

TREATMENT

Treatment is directed against the pancreatic deficiency and the pulmonary infection. Pancreatin, high protein (low fat) diet, and vitamin supplements form the nutritional approach.

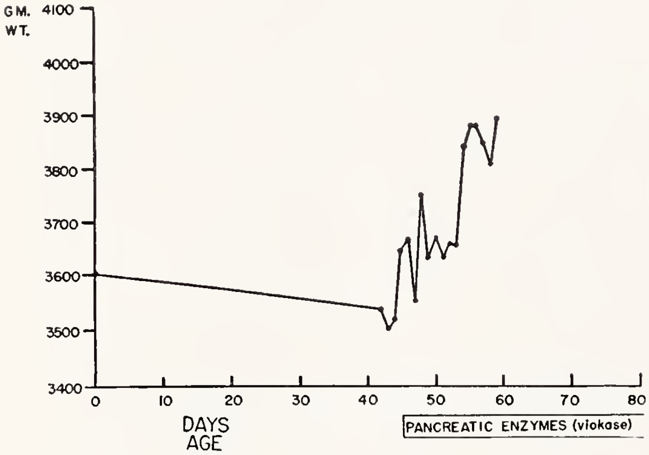


FIG. 1. The effect of pancreatin on weight gain

Their use probably favors the achievement of optimal results from the antibiotic therapy of the pulmonary infection. In the experience of this observer, use of pancreatin of adequate quality and quantity has quite regularly been followed by nutritional improvement as evidenced by weight gain and firmer stools. The exceptions have been cases with severe pulmonary infection resistant to antibiotics. Figure 1 illustrates one of the cases in which no significant change of therapy was used other than administration of pancreatin to cause the sudden weight gain. The child has had numerous upper respiratory infections since. Various antibiotics have been used, but only for short periods to terminate the bronchitis at the end of these infections. At the age of two years, she has no chronic cough, her chest x-ray is clear, and she is of average, normal size and weight.

In various cases, we have used penicillin, streptomycin, Terramycin, Aureomycin, chloramphenicol, bacitracin, neomycin, polymyxin and sulfonamides. Choice of drugs has been guided somewhat by in vitro sensitivities. Survival of these cases, usually, becomes a race between the acquisition of drug resistant organisms and the availability of new antibiotics. Drug resistant strains of Staphylococcus aureus and Pseudomonas aeruginosa are the usual problems in advanced cases. Bacitracin and acetic acid respectively have shown some promise, used by aerosol against these two organisms. Continuous use of broad spectrum antibiotics for prophylactic or suppressive effect is currently in vogue in some centers.[10] Whether such a regime improves the results to be obtained from prompt and vigorous treatment with appropriate antibiotics at times of respiratory infections remains to be proven.

Various agents by aerosol to promote liquefaction of bronchial secretions are under trial. This approach may prove to be a fundamental one in the pulmonary problem.

PROGNOSIS

Survival in most cases has been limited by pulmonary infection and acquisition of drug resistant organisms. The tendency to bronchitis varies from case to case. Two patients are known to have lived 17 years, during much of which time they did not have the benefit of modern antibiotics. With the development of new means of therapy, the life expectancy has improved to an extent which no one can now assess.

REFERENCES

1. FARBER, S.: J. Mich. State Med. Soc. **44:** 587 (1945).
2. ANDERSEN, D. H.: Pediat. **3:** 406 (1949).
3. SHWACHMAN, H.; PATTERSON, P. R., AND LAGUNA, J.: Pediat. **4:** 222 (1949).
4. JOHNSTONE, D. E. AND NETER, E.: Pediat. **7:** 483 (1951).
5. a. GIBBS, G. E.: Pediat. **5:** 941 (1950).
   b. GIBBS, G. E.: Calif. Med. **69:** 341 (1948).
6. ANDERSEN, H. AND DUEHOLM, C.: Acta Paediatrica Supp. **77:** 256 (1949).
7. McDOUGALL, C.: Pediat. **5:** 114 (1950).
8. VEGHELYI, P. V.: Pediat. **3:** 749 (1949).

9. Available from Lilly and from Astra.
10. Shwachman, H.: Pediat. **7:** 153 (1951).
11. Gibbs, G. E.: Pediat. **6:** 593 (1950).
12. West, C. D.; Wilson, J. L., and Eyles, R.: Am. J. Dis. Child. **72:** 251 (1946).
13. Lavik, P. S.; Matthews, L. W.; Buckaloo, G. W.; Lemm, F. J.; Spector, S., and Friedell, H. L.: Pediat. **10:** 667 (1952).
14. Gibbs, G. E.; Bostick, W. L., and Smith, P. M.: J. Ped. **37:** 320 (1950).

USES AND MISUSES OF ANTIBIOTICS IN SKIN DISEASES*

ISRAEL ZELIGMAN, M.D., Med. Sc.D.†

One of the more important recent advances in the treatment of disease has been the advent of potent chemotherapeutic and antibiotic drugs. Just as in other branches of medicine, the antibiotics have an important role in the treatment of cutaneous diseases.

At the Department of Dermatology of the University of Maryland School of Medicine, a team of four experienced clinicians has been investigating the benefits and disadvantages of various chemotherapeutic agents employed both systemically and topically in the treatment of diseases of the skin. The team approach has been used in order to promote objectivity in the evaluation of the effectiveness of the drugs.[1]

Bacterial Diseases

The common dermatoses of bacterial etiology are those caused by staphylococci and streptococci. Since these microorganisms are usually susceptible to chemotherapy, the antibiotics are particularly useful in cutaneous diseases caused by them. Impetigo, ecthyma, folliculitis, furuncles, carbuncles, sycosis vulgaris, cellulitis and erysipelas are treated successfully with these agents. In addition many skin disorders of other or unknown cause may become secondarily infected by these organisms. Thus fungous infections, atopic dermatitis, contact dermatitis, and seborrheic dermatitis not infrequently become secondarily impetiginized and it is imperative to treat the superimposed infection first before any attempt is made to favorably manage the primary disease. Antibiotics usually successfully clear such secondary infections.

The choice of antibiotic is at times very important. Bacterial resistance is particularly important in the treatment of patients infected with pathogenic strains of staphylococcus aureus. During the past ten years those strains which form penicillinase have become dominant in producing infections. The fact that the majority of strains of disease producing staphylococci are resistant to the antibacterial effects of penicillin should be borne in mind by all physicians.[2] Resistance of gram-positive cocci to aureomycin, chloromycetin and terramycin also occurs at times, but is not now as pressing a problem as that due to penicillin. Generally speaking, the broad-spectrum antibiotics, as well as erythromycin, bacitracin and neomycin are today effective in the treatment of staphylococcal diseases of the skin. At times tests for the sensitivity of micro-organisms to antibiotics should be used, but these are subject to varying interpretations. In actual practice, such tests are indicated when the antibiotic selected for use seems ineffective, and not as a routine measure for choosing the antibiotic for therapy.

Thus today in staphylococcal infections of the skin, if systemic therapy is to be employed, penicillin is not always the antibiotic of choice. In streptococcal infections, however, penicillin is usually the most effective agent, though the broad-spectrum antibiotics are also effective.

---

* Presented at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, Wednesday Morning, April 29, 1953, Osler Hall, Baltimore, Maryland.

† From the Department of Dermatology, University of Maryland School of Medicine, Baltimore, Md.

Pseudomonas pyocyaneus infections in otitis externa are greatly benefitted by polymyxin dropped into the external auditory canal. Chancroid, caused by the Ducrey bacillus, is effectively treated by aureomycin, terramycin and chloromycetin but in our opinion the sulfonamides represent the treatment of choice because they are not spirochetocidal and hence do not mask early syphilis. Distinct advances have recently been achieved in the treatment of the many manifestations of cutaneous tuberculosis. Amongst others, streptomycin administered systemically and also injected locally is very helpful.

Fungous Infections

The antibiotics are not effective in the treatment of superficial fungous infections of the skin per se but are very beneficial in clearing the secondary staphylococcal and/or streptococcal superinfection in cases of tinea circinata, tinea capitis, tinea cruris and in dermatophytosis and dermatophytid. Though much has been written about the dangers in the use of penicillin and other antibiotics in the treatment of dermatophytid, we have rarely seen instances of dermatophytid exacerbated by antibiotics including penicillin, and in fact advocate their use in secondarily infected dermatophytosis and dermatophytid.

One of the important contraindications and dangers in the use of the broad-spectrum antibiotics is monilial infection. As is well recognized, candida albicans thrives when aureomycin, terramycin and chloromycetin are administered with the production of perleche, glossitis, stomatitis, nausea, vomiting, diarrhea, perianal and perivulvar dermatitis and other pruritic eruptions. Neomycin applied topically not infrequently produces eruptions from which candida albicans can be cultured.[3]

The effect of the antibiotics on the deep fungous infections of actinomycosis, blastomycosis, sporotrichosis and coccidioidomycosis appears to be inconstant with various combinations at times successfully employed.

Parasitic Diseases

Syphilis has been struck what appears to be a severe blow since the advent of penicillin. Various regimes are employed but generally speaking, six million units are given for early syphilis and from six to twenty million for various manifestations of late syphilis. In the usual doses employed, streptomycin appears to be non-spirochetocidal, but aureomycin, terramycin, chloromycetin and erythromycin are antisyphilitic drugs, though their ideal dosages are still not determined.

The antibiotics materially speed recovery from the staphylococcal and streptococcal infections superimposed on a scabetic infestation.

Viral Diseases

These chemotherapeutic agents are helpful in combating the secondary infection superimposed on herpes simplex and on herpes zoster. Not infrequently the broad-spectrum antibiotics stop the pain of herpes zoster but they do not prevent postzosteriform pain.

There have been a few individual case reports on the treatment of molluscum contagiosum but we have observed no benefit from the administration of any of the antibiotics in this disease.

Lymphogranuloma venereum is benefitted by the broad-spectrum antibiotics but the acute phase is probably best handled by the sulfonamides because of their non-spirochetocidal effect. Rectal stricture has recently been reported to be materially aided by these antibiotics.

We have been particularly impressed with the effect of chloromycetin and of erythromycin on granuloma inguinale. At times, these ulcerative lesions of ten or more years duration completely heal within two to three weeks. Aureomycin, terramycin and streptomycin are also beneficial but do not produce nearly so dramatic a cure and are not infrequently attended by relapses.

ALLERGIC DISEASES

Erythema multiforme bullosum is frequently but not always favorably affected by the systemic administration of penicillin, aureomycin, terramycin or chloromycetin. Whether the antibiotics affect the secondary infection of the bullae or the affection per se is undetermined. We have not been impressed with the beneficial results in erythema nodosum, nor is urticaria usually improved with antibiotics.

Neither contact dermatitis nor atopic dermatitis is basically affected by antibiotics but the secondary pyodermic infection of these allergic eruptions is markedly improved by them.

ENDOCRINE DISEASES

Similarly seborrheic dermatitis is not improved by these chemotherapeutic agents, but when there is secondary impetiginization, they are particularly helpful and accelerate good management of the eruption.

The pustular and cystic types of acne are aided by the administration of antibiotics, but upon withdrawal of these drugs, the eruption frequently relapses.

INFLAMMATORY DISEASES OF UNKNOWN ETIOLOGY

Lichen planus, psoriasis and pityriasis rosea are not particularly helped by antibiotics. At times, pemphigus vulgaris is improved with systemic administration, but today the steroid hormones are the treatment of choice. The systemic and localized forms of lupus erythematosus and of scleroderma are not benefitted by these drugs.

SYSTEMIC VERSUS TOPICAL THERAPY

In the treatment of primary or secondary pyodermas, the antibiotics are helpful when administered both systemically or topically. For localized areas, topical treatment is more practical but for widespread or generalized or deep pyodermas, systemic administration is recommended. This is especially important when one considers that the skin from widespread cases of pyoderma is the portal of entry in many cases of glomerulonephritis.[4]

Obviously any of these drugs administered systemically is a potential allergen and when it is known that a patient has manifested an allergic reaction in the past or an undesirable side-effect, another antibiotic should be employed. As to topical therapy, penicillin, streptomycin and chloromycetin are such potent sensitizers when applied to the skin, that they should not be used locally.

RECAPITULATION

1. The antibiotics are indicated in the treatment of primary and secondary pyodermas; many skin staphylococci are not now penicillin-sensitive so that other antibiotics must frequently be employed.
2. Penicillin is not necessarily interdicted in the treatment of secondarily infected dermatophytosis and dermatophytid.
3. Penicillin is the chemotherapeutic agent of choice in the treatment of syphilis.
4. Chloromycetin and erythromycin give dramatically gratifying results in the treatment of granuloma inguinale.
5. Erythema multiforme frequently responds to the administration of antibiotics.
6. Most other cutaneous diseases are not benefitted by the administration of antibiotics or are only temporarily or inconstantly helped.
7. For pyodermas, antibiotics should be administered systemically for widespread and deep involvement and topically for localized involvement.
8. Antibiotics may cause undesirable side-effects or allergic reactions; because of their high skin sensitizing indices, penicillin, streptomycin and chloromycetin should not be employed topically.

REFERENCES

1. (a) ROBINSON, H. M., JR., ZELIGMAN, I., SHAPIRO, A., AND COHEN, M. M., Acquired Contact Sensitivity to Chloromycetin. J. Invest. Derm. **17:** 205–206, 1951.

(b) Robinson, H. M. Jr., Zeligman, I., Shapiro, A. and Cohen, M. M., Leukopenia, A Complication of Chloromycetin Therapy of Chronic Discoid Lupus Erythematosus. J. Invest. Derm. **19**: 199–204, 1952.

(c) Robinson, H. M., Jr., Shapiro, A., Zeligman, I., and Cohen, M. M., Terramycin in Treatment of Dermatoses. South. Med. J. (accepted for publication).

(d) Robinson, H. M., Jr., Zeligman, I., Shapiro, A., and Cohen, M. M., Chloromycetin in Treatment of Dermatoses. Bull. School of Medicine University of Maryland (in publication).

(e) Robinson, H. M., Jr. and Cohen, M. M., Erythromycin in Treatment of Granuloma Inguinale. J. Invest. Derm. (accepted for publication).

(f) Robinson, H. M., Jr. and Zeligman, I., Erythromycin Locally in Treatment of Pyodermas. J. Invest. Derm. (accepted for publication).

2. Long, P. H., Bacterial Resistance as a Factor in Antibiotic Therapy. Bull. New York Acad. Med. Dec. 1952.

3. (a) Livingood, C. S., Nilasena, S., King, W. C., Stevenson, R. A., and Mullins, J. F., Pyogenic Infections Treated with Neomycin. J. A. M. A. **148**: 334, 1952.

(b) Kile, R. L., Rockwell, E. M., and Schwarz, J., Use of Neomycin in Dermatology. J. A. M. A. **148**: 339, 1952.

4. (a) McCullough, G. C., Coffee, J. Y., Trice, P. A., Jr., Stone, J. J., and Crandall, A. L., Acute Glomerulonephritis: Impetigo as Etiologic Factor. J. Pediat. **38**: 346–348, 1951.

(b) Callaway, J. C. and O'Rear, H. B., Pyogenic Infections of Skin: Etiologic Factor in Acute Glomerulonephritis of Children. A.M.A. Arch. Dermat. and Syph. **64**: 159–163, 1951.

DUAL REGISTRANTS HAVE 30 DAYS TO ASK RESERVE COMMISSIONS

The AMA Washington Letter, No. 43

Selective Service has instructed local draft boards to give physicians registered both under the regular doctor drafts 30 days in which to make application for a reserve commission, once they are called up. The agency said applicants, in applying on a form supplied by their boards, may indicate their first and second choice of service. Selective Service adds that the military department involved will notify the state director of Selective Service of any registrant who doesn't accept a commission within 30 days after it is tendered. Such registrants would then face early induction as privates.

The new instructions follow the October 8 master directive of the Defense Department implementing the revised doctor draft last June. The directive, among other things, clarified the status of doctors with dual responsibility, and the Selective Service instructions completed the picture. Selective Service Director Lewis B. Hershey commented: "It is the policy of the armed forces to utilize in a commissioned rather than enlisted status all special registrants who qualify for such commissions. This headquarters concurs in that policy."

NSF MAKES 15 GRANTS IN MEDICAL FIELDS

The AMA Washington Letter, No. 43

More than 10% of the National Science Foundation awards announced so far for fiscal 1954 are of interest to the medical profession. Of the 123 awards for $1,332,000, fifteen grants totaling $201,300 are in medical or allied fields. They average 2.4 years $13,420 each as compared with an average 1.8 years and $10,828 each for the entire group. Some medically significant work to be done under these NSF grants include research on amino acid metabolism, physiological development of regulatory functions, glucose penetration into cells, x-ray studies of viruses, and hydrodynamic properties of proteins. Additional grant proposals are being studied and NSF decisions will be announced later.

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

The following articles appeared in the Cumberland Evening Times:

KNOWING OWN BLOOD TYPE IMPORTANT

The medical director of Civil Defense for Allegany County has issued an appeal for all persons to have their blood typed.

Dr. Leslie E. Daugherty, director, said that information would save many lives in event of an attack by an enemy. He added that 44 per cent of Allegany County citizens have type O and 66 per cent other types. When a person knows his blood type, he should carry a note of it with him constantly.

MEDICAL CARE WAITING LIST EXCEEDS 400

Allegany County Medical Care waiting lists—which recently stood at the 427 mark—have ranged from 300 to more than 400 since the quota system was adopted by the State Board of Health.

The adoption of the quota system followed a cut in state appropriations to provide medical care for those who cannot afford to pay for it.

In this County, it means that only 2,402 persons were authorized to receive free medical and dental care at one time.

To Meet Emergencies

However, when the system was adopted, provisions were made to take care of emergency cases, so that those in dire need of medical attention and drugs would not suffer. Officials believe such needs are being met.

Medical care is provided by the state for two groups—those who are receiving assistance from the Allegany County Welfare Board, and the medically indigent. The last group includes persons who have some income but are unable to make it stretch to meet the costs of medical attention.

Early in August, the Allegany County Health Department stopped issuing new Medical Care cards until the rolls dropped to the 2,402 mark.

Nobody was dropped from the program, but as six-month authorizations expired, persons were placed on the waiting list.

Will Mail Cards

When the quota allows, new authorizations are mailed to the persons on the top of the waiting lists.

New applicants are placed on the list after renewals and will be issued cards as their names come up.

Dr. Winter R. Frantz, county health officer, said that except in cases of emergencies, it is useless to contact the Health Department about Medical Care cards, since they are issued and mailed automatically whenever the quota drops to the 2,402 mark.

The state has allotted $93,313 for Medical Care costs in Allegany County this year, estimating that 2,402 persons can be given medical care at an average cost of $38.02.

Last year, when $101,051 was spent for the program here, average enrollment was 2,658.

The following articles appeared in the Cumberland Evening Times:

DR. FRANTZ COMMENDS WORK OF COUNTY LAY HEALTH GROUP

Dr. Winter R. Frantz, county health officer, was the speaker at a recent meeting of the Allegany County Public Lay Health Council in the Union Street County Building. Miss Mary Margaret Smith, R. N., presided and introduced Dr. Frantz.

Dr. Frantz commended the council for its work and cooperation with the Health Department. He stated 520 clinics are held by the Health Department each month and that lay assistance is given at nearly all of them.

Speaking on the topic, "Public Health," Dr. Frantz stated "More people are becoming health conscious due to public education."

Mrs. Elizabeth Nave, Mrs. Charles Heller and Mrs. Lester McGill were named to the nominating committee to select a slate of officers to be elected at the November meeting.

Reports were given by the various group chairmen including Mrs. Albert Snelson, Corriganville; Mrs. Nave, City; Mrs. Cecelia Edmondson, South Cumberland; Miss Smith, LaVale, and Mrs. Lester McGill, Cresaptown.

The following committee was named to plan a Christmas party: Mrs. Patrick Allender, Chairman; Mrs. Heller, Mrs. Edmondson, Mrs. Nave, Mrs. Snelson, Mrs. McGill, Miss Smith, Mrs. Thomas Williamson, Mrs. Helen Bogel, Mrs. Martha Hamilton and Mrs. Leila Vandegrift.

Health nurses will be hostesses to the workers at the November meeting.

Student Nurses to Take Training

A week of training in public health nursing will be given senior students of Memorial and Sacred Heart Hospitals by the Allegany County Health Department.

Dr. Winter R. Frantz, city and county health officer, said the 1953–54 program will start soon, when two student nurses from Memorial Hospital will be assigned to the department for a week.

The training for Memorial Hospital students will continue through January.

Similar field training for students at Sacred Heart School of Nursing will begin in February.

Dr. L. I. Brings, Cumberland, Dr. Martin M. Rothstein, Frostburg; Dr. E. Irving Baumgartner and Dr. Thomas F. Lusby, II both of Oakland, and Dr. Milton Tepfer, of Friendsville, attended the fifth annual scientific assembly of the Maryland Academy and General Practice at the Lord Baltimore Hotel, Baltimore, on Wednesday, October 21.

Allegany County Medical Director of Civil Defense has issued an appeal for all persons to have their blood typed.

Allegany County Physicians Participate in State-Wide Air Alert

During the recent statewide air alert, six Casualty Clearing Station medical directors had reported within three minutes of the first alarm that they were standing by for mobilization. All key posts were alerted and ready to act when the all-clear signal came.

Allegany County has six complete stations and the following physicians serve as directors; Dr. O. R. Roth, Dr. Clay Durrett, Dr. Leland Ransom, Dr. Leo H. Ley, Jr. of Cumberland and in Frostburg, Dr. Martin M. Rothstein, and at Westernport, Dr. J. Norman Reeves. The chief medical director of Civil Defense for Allegany County is Dr. Leslie E. Daugherty, of Cumberland.

Student nurses now receive training in public health work with the Allegany County Health Department.

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

Plans for the 1953–54 monthly meetings are crystallizing. The final programs will be distributed soon. The December, "President's Meeting," will be on tuberculosis. President Fort has arranged an all-out review featuring experts from Denver, Trudeau, Philadelphia, New York City, and Baltimore who will give us the best and most advanced tactics in the attack on the white plague. Baltimore's new Veteran's Administration Tuberculosis Hospital will co-sponsor the program. It will have the endorsement of State and National Tuberculosis organizations.

Programs for next year will not all be of the panel type. A reversion to lectures and case presentation is planned for the January Meeting on regional enteritis and "ulcerative colitis," according to Doctor Arthur Weinberg, chairman of the Program Committee.

President Fort's innovation: suggestions from the general membership to the Nominating Committee concerning officers for the coming year, will bear fruit this month. Will the idea be so startling that no one takes it too seriously? Will it be so welcome that the committee is swamped? Will it be an effective step away from the "Wheel-horse"-type of operation of this Society with two thousand members and one hundred voters at meetings?

The Committee on Postgraduate Courses probably will report the complete statistics returned on their questionnaire. Chairman Harry M. Robinson, Jr., divulges that in the month after two thousand inquiries were sent out there were over six hundred replies. Very few were critical, most were helpful. Nearly six hundred wanted the postgraduate courses continued. The general desire, was for more than one short course during the winter.

In response to the requests, four courses have been arranged for the January-April period. It is regrettable that at least one could not have been held during President Fort's term of office because of his effective interest in getting them started. Of the four that led the poll, "Fluid Balance" will be given in April, Dermatology in January, Hematology and Endocrinology in February. Lecture-demonstration will be the chief form of presentation.

These postgraduate courses have aroused interest in areas outside the city. Chairman Robinson and President Fort feel that this is strictly a Baltimore City Medical activity, free to all members, for whom it is primarily intended. Other physicians are welcome as guests. There is no intention nor desire to interfere or conflict with the University of Maryland Medical School's Committee on Postgraduate Studies headed by Doctors Howard Bubert and John Wagner and their extensive staff.

CANCER SECTION

Arthur G. Siwinski, M.D., *Secretary*[*]

The meeting of the Cancer Section of the Baltimore City Medical Society was held on the 14th of October 1953 at Bethesda, Maryland. The section were the guests of the National Cancer Institute. Thirty-eight members gathered at the Officers Club of the Navy Medical Center at 6:00 p.m. Dr. Seager made arrangements for a very tasty meal which all enjoyed. After the dinner the group prepared to go to the new clinical center of the National Cancer Institute where we were joined by about twelve members who had been unable to attend the dinner.

Dr. Seager and Dr. John R. Heller, Jr. then conducted the group through part of the building to give us an idea of their set-up. Everyone was much impressed with the well equipped patient's rooms, and the excellent facilities for laboratory investigation. After this the entire group gathered in the fourteenth floor for the scientific session. The meeting was called to order by Dr. Edwin H. Stewart, Jr. at 8:25 p.m. After thanking our hosts for making such nice arrangements for us Dr. Stewart turned the meeting over to Dr. Burroughs Mider.

In a few words Dr. Mider outlined what was expected to be accomplished in the center and then introduced Dr. Robert Smith the Chief Surgeon. Dr. Smith gave us a brief outline of the clinical program of investigation which his section will in the future attempt. At the present time Dr. Smith states that the current interest is in pelvic and head and neck problems. Dr. Edward F. Lewison asked if there were any formal mechanism for the admission of patients to the center. Dr. Smith and Dr. Heller answered this question stating at present there is no formal mechanism and that contacts be on a personal basis. He stated, however, that if the group so desired a regular mechanism could be set up.

Dr. Mider then introduced Dr. Roy Hertz. Dr. Hertz discussed briefly the endocrine factors which play a part in the treatment of carcinoma of the prostate and their possible mode of action. He then went on to discuss the relationship of folic acid and biotin.

The meeting adjourned at 9:55 p.m.

FREDERICK COUNTY MEDICAL SOCIETY

JESSE S. FIFER, M.D.

Journal Representative

Riggs Cottage Sanitarium Changes Hands

The Riggs Sanitarium at Ijamsville, Frederick County, in continuous operation for the treatment of nervous and mental patients, since its inception in 1896, has been sold by Dr. McAdoo to Dr. Joseph Lerner of Devan, Pennsylvania. Dr. Lerner took over the operation of the institution on October 1, 1953.

Doctor McAdoo and his wife, Dr. Julia Kagen, are retiring on their ranch in the Ozark Mountains for a period of one year. In the meantime, they will decide whether or not and where they will resume the practice of neuropsychiatry.

Dr. Joseph Lerner, the new owner of the institution has a background of many years of training and varied experience, in the field of neuropsychiatry. He is a diplomate of the American Board of Psychiatry and Neurology. Mrs. Lerner is a graduate of the Jefferson Medical College Hospital Training School.

---

[*] Cancer Section, Baltimore City Medical Society.

Dr. George Henry Riggs, founder of the Riggs Sanitarium, was born at Ijamsville in 1870 and was graduated from the University of Maryland, School of Medicine in 1891. For about five years he was on the staff at the Conrad's Sanitarium at Relay, Maryland, the first private institution in the State for nervous and mental diseases.

Dr. Riggs then returned to his native community and established the Riggs Sanitarium for the treatment of nervous and mental patients. In 1939, Dr. Riggs sold the institution to Dr. McAdoo, but continued the practice of medicine in the county for a total of sixty years. He is now retired and lives with a daughter, Mrs. England, at Arlington, Virginia.

The Riggs Sanitarium has a patient capacity of about thirty and has been devoted exclusively to the treatment of the nervous and mentally ill patients for which it is well adapted by its inviting environment, on a beautiful lawn with gardens and a forty-two acre farm, a small quiet hamlet and a picturesque country side.

The McAdoos won the love and respect of their fellow physicians in Frederick County during their stay here. In their honor and as a farewell to them, Dr. and Mrs. Byron D. White gave a party at their home on Rockwell Terrace on September 23rd, to which 18 physicians and their wives were invited. The McAdoos left for their home in the west October 1st, with best wishes of the members of the Frederick County Medical Society.

PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

J. M. WARREN, M.D.

Journal Representative

The Prince George's County Medical Society devoted its October meeting to Civil Defense. Dr. Welch, who has charge of the State Civil Defense Program, addressed the society and discussed the great need for an active Civil Defense Program in the County. The doctors in the County have been organized through Dr. Brainin's committee, each one being assigned to a hospital unit or to a casualty clearing station. We are encouraging the doctors to study emergency medical treatment and help train non-professional personnel in the various casualty clearing station groups.

Dr. Moyers, reporting from the Maryland Medical and Chirurgical meeting spoke of the need for increased medical dues. He alluded to the fact that the Federal Government may try to assume the responsibility for the medical care of all veterans and their families some time in the near future. We feel that this is just another step towards socializing medicine, and hope that our organization will fight to prevent it.

Our November meeting will be devoted to a banquet and dance to be held at the Statler Hotel in Washington. This program will be under the supervision of Frederick Musser and his entertainment committee. This was well attended last year and a good time was had by all. We hope to have even a better attendance this year.

WICOMICO COUNTY MEDICAL SOCIETY

WILBER R. ELLIS, Jr., M.D.

Secretary-Treasurer

The first fall meeting of the Wicomico County Medical Society was held at 8:30 p.m., on October 12, 1953, in Salisbury, Maryland. Through the efforts of Dr. Alfred S. Ledermann of this Society, a very complete symposium on psychiatry was held. The following was the program:

I. *Mental Illness and the Community.* George F. Sutherland, M.D., Chief, Division of Psychiatric Education and Training, Department of Mental Hygiene, State of Maryland, and Associate Professor of Psychiatry, Duke University School of Medicine, and Earl K. Holt, M.D., Assistant Commissioner, Department of Mental Health, State of Maryland.

II. *Principles of Treatment of the Patient in a Private Psychiatric Hospital.* Irving J. Taylor, M.D., Medical Director, Pinel Clinic, Ellicott City, Maryland.

III. *Schizophrenia.* George Currier, M.D., Superintendent, Eastern Shore State Hospital, Cambridge, Maryland.

IV. *Psychosomatics.* Louis Krause, M.D., Professor of Medicine, University of Maryland School of Medicine, Baltimore, Maryland.

There was a large attendance made up of local physicians, members of surrounding counties of Maryland, and physicians from nearby counties of Delaware and Virginia.

Members of the Society wish to thank Dr. Ledermann and his guest speakers for a very interesting and informative program.

DEFENSE DEPARTMENT ISSUES DIRECTIVE ON REVISED DOCTOR DRAFT

The AMA Washington Letter, No. 41

With the issuance October 8 of Defense Department's directive to implement the revised doctor draft act, the three military services are prepared to put into effect all changes called for by the new law. The directive has been more than three months in preparation. Pending its official release, Army, Navy, and Air Force have delayed acting on a number of things, including the upward adjustment in grade for certain officers.

The directives restates much policy that has been in effect for some time, but also makes the following new points:

GRADE: The law requires appointment, reappointment, or promotion to a grade "commensurate with professional education, experience or ability." The directive retains the present scale of grades, based on years of experience, and states that promotions must be given "at the earliest practicable date" to men now on active duty who qualify for higher grades. In effect, this means that a physician's experience alone will determine the grade in which he serves, whether he is on active duty now or is commissioned or recalled in the future. Eliminated are such limiting factors as shortage of higher grades in a table of organization, the arbitrary commissioning of Priority I and II men on the basis of cutoff dates, and delays pending action of officers' boards. (The following scale is used to determine grades: if less than four years' professional experience since graduation, first lieutenant; four but less than 11 years, captain; 11 but less than 18, major; 18 or more, lt. colonel; comparable grades in the Navy.)

NEW INVESTIGATIVE OPPORTUNITIES FOR MILITARY PATHOLOGISTS

The AMA Washington Letter, No. 43

The $7 million Armed Forces Institute of Pathology, whose cornerstone was laid October 20, will offer pathologists of the three services an opportunity to expand their work under ideal conditions. Available to them now will be investigative laboratories in the basic sciences, whereas in the old building they were mostly limited to studies in morphologic pathology. The outside structure is like a one-piece concrete box, one of the few buildings in the country designed to resist atomic bombs. Inside, the flexible design makes use of demountable steel partitions. The building will be completely equipped with an intercom or "squawker" system, and numerous television outlets will make an autopsy visible to any number of observers. Color television connects the operating rooms at Walter Reed hospital with the Institute's labs, giving the surgeon and the pathologist an opportunity to follow each other's activities. Pneumatic tubes will carry specimens directly from operating rooms to labs.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

ARTHRITIS

LOUIS KRAUSE, M.D.*

Arthritis is a condition that goes back to time immemorial. The skeletal remains of earliest Egypt give evidence of the presence of this disease at that time. I can testify to this myself as a result of my observations of the mummies recovered from the many ancient graveyards in Egypt. The comparative anatomists have shown us how frequently it is present outside of the human race, such as in cattle, rabbits and mice. There is also some reason to believe that it was probably present in the dinosaur. This pushes us back to the Third Inter-Glacial Period.

Much literature has been written on the subject by the ancient writers; and one of the best examples is found in the New Testament, Luke 13:11, which goes as follows:

> "And behold, there was a woman which had a spirit of infirmity eighteen years, and was bowed together, and could in no wise lift up herself."

Even though the disease is so old, its cause escapes us and treatment is still very inadequate. The following list of books will give you the story of Arthritis from earliest days up to the present time and are available in our Library:

Allison, N. and Ghormley, R. K. Diagnosis in joint disease; a clinical and pathological study of arthritis. N. Y., Wood, 1931.

Beck, B. F. Bee venom therapy . . . N. Y., Lond., D. Appleton-Century, 1935.

British national committee on chronic rheumatic diseases. Annual report, no. 3. Lond., H. K. Lewis & Co. ltd., 1937.

Buckley, C. W. Arthritis, fibrositis and gout. Lond., H. K. Lewis & Co. ltd., 1938.

Burckhardt, H. Arthritis deformans und chronische gelenkkrankheiten. Neue deutsche chirurgie v. 52. Stutt., F. Enke, 1932.

Cecil, R. La F. The diagnosis and treatment of arthritis. Oxf. Mono. on diag. and treatment v. 6. N. Y., Oxf. univ. pr. (c1929).

Coates, V. and Delicati, L. Rheumatoid arthritis and its treatment. Lond., H. K. Lewis & Co., ltd., 1931.

Comroe, B. I. Arthritis and allied conditions, 3rd ed. Phila., Lea & Febiger, 1944; also 4th ed., 1949.

Crowe, H. W. Bacteriology & surgery of chronic arthritis and rheumatism, with end-results of treatment. Lond., N. Y., Humphrey Milford, Oxf. univ. pr., 1927.

Crowe, H. W. The treatment of chronic arthritis and rheumatism. Lond., N. Y. (etc.) Humphrey Milford, Oxf. univ. pr., 1926.

Daniel, P. Arthritis, a study of the inflammatory diseases of joints, ed. by J. Cantlie. N. Y., Wm. Wood & Co., 1911.

Freund, E. Gelenkerkrankungen; einfuhrung in die Pathologie und Therapie. Berl., Urban & Schwarzenberg, 1929.

Hoffa, A. J. and Wollenberg, G. A. Arthritis deformans und sogenannter chronischer gelenkrheumatismus. Stutt., F. Enke, 1908.

Holbrock, W. P. and Hill, D. F. Manual of rheumatic diseases. Chic., Year Book Pub., 1950.

Jones, R. L. Arthritis deformans: comprising rheumatoid arthritis, osteoarthritis, and spondylitis deformans. N. Y., Wood, 1909.

Kling, D. H. The synovial membrane and the synovial fluid with special ref. to arthritis and injuries of the joints . . . Los Angeles, Med. Pr., 1938.

Knaggs, R. L. The inflammatory and toxic diseases of bone. Brist., John Wright & Sons, ltd., Lond., Simpkin, Marshall, Hamilton, Kent & Co., ltd., 1926.

Lautman, M. F. Arthritis and rheumatic disease. N. Y., Whittlesey, 1936.

Llewellyn, R. L. J. Aspects of rheumatism and gout. Lond., Heinemann, 1927.

Llewellyn, R. L. J. and Jones, B. Fibrositis (gouty, infective, traumatic). N. Y., Reban Co., 1917.

---

* Chairman, Library Committee.

Llewellyn, R. L. J. Gout. Lond., Heinemann, 1920.

Loomis, A. L. and Thompson, W. G. System of practical medicine, v. 4. N. Y., Phila., Lea Brothers & Co., 1898.

Margolis, H. M. Conquering arthritis. N. Y., Macmillan, 1931.

Nicoll, S. Dissertatio medica inauguralis de arthritide. Edin., Balfour et Smellie, 1776.

Pemberton, R. Arthritis and rheumatoid conditions; their nature and treatment. Phila., Lea, 1929; also 2d ed., 1935.

Pemberton, R. and Osgood, R. B. The medical and orthopaedic management of chronic arthritis. N. Y., Macmillan, 1934.

Pribham, A. Chronischer Gelenkrheumatismus und Osteoarthritis Deformans, (In Nothnagel. Specielle Pathologie und Therapie, v. 7, pt. 2. Wien, Alfred Hölder, 1902.)

Steinbrocker, O. Arthritis in modern practice. Phila., Saunders, 1941.

Stockman, R. Rheumatism and arthritis. Edin., W. Green & Son, ltd., 1920.

Talbott, J. H. Gout and gouty arthritis. N. Y., Grune & Stratton, 1953.

Thomson, F. G. and Gordon, R. G. Chronic rheumatic diseases, their diagnosis and treatment. Lond., Milford, 1926.

Wilde, P. The physiology of gout, rheumatism, and arthritis, as a guide to accurate diagnosis and efficient treatment. N. Y., Wood, 1922.

Wyatt, B. L. Chronic arthritis and fibrositis; diagnosis and treatment. Balto., W. Wood & Co., 1933.

Wyatt, B. L. Chronic arthritis and rheumatoid affections, with recovery record. N. Y., W. Wood, 1930.

A SELECTED LIST OF PUBLICATIONS RECENTLY ADDED TO THE LIBRARY

* Barta, F. R. Moral theory of behaviour. Springfield, Thomas, 1952.

* Benda, C. E. Mongolism and cretinism. 2d ed. New York, Grune and Stratton, 1949.

Biggs, R. and Macfarlane, R. G. Human blood coagulation. Oxford, Blackwell, 1953.

* Binger, C. A. L. Personality in arterial hypertension. New York, American Society for Research in Psychosomatic Problems, 1945.

* Bond, E. D. Dr. Kirkbride and his mental hospital. Philadelphia, Lippincott, 1947.

* Bond, E. D. Thomas W. Salmon, psychiatrist. New York, Norton, 1950.

* Brill, A. A. Lectures on psychoanalytic psychiatry. New York, Knopf, 1946.

Browne, D. G. and Tullett, E. V. The scalpel of Scotland Yard. New York, Dutton, 1952.

* Clark, M. Medicine on the march. New York, Funk & Wagnalls, 1949.

Dameshek, W. and Welch, C. S. Hypersplenism and surgery of the spleen. New York, Grune & Stratton, 1953.

* Deri, S. Introduction to the Szondi test. New York, Grune & Stratton, 1949.

* Evans, B. The psychiatry of Robert Burton. New York, Columbia University Press, 1944.

* Fischer, S. Principles of general psychopathology. New York, Philosophical Library, 1950.

Fulton, J. F. Frontal lobotomy and affective behaviour. New York, Norton, 1951.

Graybiel, A. Electrocardiography in practice. 3d ed. Philadelphia, Saunders, 1952.

* Hirsh, Jos. First hundred years of the Mt. Sinai Hospital of New York. New York, Random, 1952.

* Harvard University School of Public Health—Proceedings of the symposium in industrial medicine. Boston, Harvard University Press, 1953.

Index generalis. Paris, Dunod, 1953.

* Kendall, H. O. Muscles, testing and function. Baltimore, Williams & Wilkins Co., 1949.

Kinsey, A. C. Sexual behaviour in the human female. Philadelphia, Saunders, 1953.

* London, L. S. Sexual deviations. Washington, Linacre Press, 1950.

MacBryde, C. M. Signs and symptoms. 2d ed. Philadelphia, Lippincott, 1952.

Miller, S. E. Textbook of clinical pathology. 4th ed. Baltimore, Williams & Wilkins, 1952.

* Napier, L. Principles and practice of tropical medicine. New York, Macmillan, 1946.

* Nicola, T. Atlas of surgical approaches to bones and joints. New York, Macmillan, 1945.

---

* Indicates gifts.

* Nixon, P. I. History of the Texas Medical Association. Austin, Texas, University of Texas, 1953.

* Orley, A. Neuroradiology. Springfield, Thomas, 1949.

Palmer, E. D. Esophagus and its diseases. New York, Hoeber, 1952.

* Psychiatry and the war. Springfield, Thomas, 1943.

* Rapaport, D. Diagnostic psychological testing. Chicago, Yearbook Publ., 1945–46. 2 vols.

* Rees, J. R. The shaping of psychiatry by war. New York, Norton, 1945.

* Rosenzweig, S. Psychodiagnosis. New York, Grune & Stratton, 1949.

* Rusk, H. A. Living with a disability. New York, Blakiston, 1953.

Scientific and learned societies of Great Britain. London, Allen & Unwin, 1952.

Shock and circulatory homeostasis. New York, Josiah Macy, Jr. Foundation, 1953.

Starr, I. Physiologic therapy for obstructive vascular disease. New York, Grune & Stratton, 1953.

* Stein, M. I. The thematic apperception test. Cambridge, Addison-Wesley, 1948.

* Stitt, E. R. Practical bacteriology. 10th ed. Philadelphia, Blakiston, 1948.

* Tompkins, S. S. Contemporary psychopathology. Cambridge, Harvard University Press, 1943.

* Walshe, F. M. R. Diseases of the nervous system. 5th ed. Baltimore, Williams & Wilkins, 1947.

The world of learning. London, Europa pub., 1953.

Yearbook of medicine. Chicago, Yearbook, 1953.

JUSTICE DEPARTMENT TO HANDLE NON-SERVICE CONNECTED INVESTIGATIONS

The AMA Washington Letter, No. 41

Under a new plan about to be put into effect by Veterans Administration, the *Department of Justice* will be called in to handle cases of suspected fraud concerning the "inability to pay" declaration of veterans with non-service connected disabilities. VA itself is forbidden by law to look behind the veteran's statement that he can't afford private treatment. According to testimony introduced in Congressional hearings, this has resulted in many abuses.

The new arrangement provides that if a VA hospital manager has good grounds to suspect that the veteran's claim of indigency is fraudulent, he will confer with federal law-enforcement officials. An investigation will then be conducted by Justice Department, the regular law-enforcement arm of the federal government. If the facts justify prosecution, the case will be taken to federal court. There the government will have to prove that the veteran in question set out "premeditatedly, purposefully and intentionally" to defraud the government.

Also nearing the announcement stage is a tightening up of the questionnaire filled out by veterans with non-service connected conditions when they apply for VA hospitalization. VA medical and legal officials have been working on the new wording since last spring.

It is expected the revised form will call on the veteran to supply more information about his finances. The new questions are being given a final check by VA attorneys before presentation to the Administrator.

Health Departments

LEGAL PROCEDURES IN TUBERCULOSIS CONTROL

EDWIN G. RILEY, M.D.*

Denton, Md.

In Maryland legal means are resorted to by State and County Health Departments only when the health of an individual is a serious threat to others and all attempts by the educational route have failed.

The recent panel discussion on tuberculosis reported in the Maryland State Medical Journal mentioned the use of legal procedures to force treatment for this disease.[1] An article in the United States Public Health Reports states this to be the only method of handling the recalcitrant tuberculosis patient.[2]

In Caroline County among the sixty-four known cases of tuberculosis four have presented difficult problems of accepting care. After every other method had failed it was felt that legal steps were the last resort.

P.R.—White, male, twenty-eight years old, living with his wife, one six-year old daughter, his brother, his brother's wife and two small children.

In 1948 he was diagnosed by the Health Department as having moderately advanced active tuberculosis with a positive sputum. He refused to accept this diagnosis until it was confirmed by his own physician. At this time the children were tuberculin negative. He entered the sanatorium, gained weight, and improved in general. After being in the hospital five months, he absented himself. The patient was seen in the Health Department Clinic and at home during the next four months. Finally he stopped attending the clinic saying that he was unable to obtain the money to travel the twenty miles from his home. It was then suggested that he return to the hospital to have treatment for pleural adhesions. He refused.

The patient and his family were given aid by the Welfare Department although it was suggested that if he did not obtain treatment this assistance might be discontinued. He replied he would go to work. Aid was continued.

Finally a neighbor complained that the man was exposing others in the neighborhood. It was now learned that he was being treated by his local physician although his course was progressively worse. He began avoiding representatives of the Health Department. A second neighbor called the Health Department because she was concerned that her children were being exposed to the patient. The man's physician was consulted. He too had urged the man to be hospitalized without success.

The health officer warned P.R. that it was the opinion of his own physician as well as the health authorities that he should return to a sanatorium or legal steps would be taken to see that he was isolated. After the man expressed repeated belligerence a trial was arranged. He was found guilty as charged and sentenced to nine months with a suspended sentence if he would immediately enter a sanatorium. This he agreed to do.

He was admitted to a state sanatorium within several days. Four days later he left. The health officer again visited the man in his home and was told that the patient would not return to the sanatorium. A second warrant was issued and the man brought into court. At this time the magistrate told him he must be in a hospital within twenty-four hours. The next day it was learned that the patient had seen a local lawyer who had arranged for the patient to be admitted to a clinic in Philadelphia which treats all stages of tuberculosis on an out-patient basis. It was agreed that he could go to Philadelphia as long as he did not live in Maryland while taking treatment. He entered the clinic as an in-patient. His family informed the Health Department that he was quite satisfied at the clinic and at the end of four months was said to be sputum negative and returned home.

A letter has been received from the Philadelphia

---

* Health Officer, Caroline County.

[1] "Symposium on the Tuberculosis Problem in Baltimore," Maryland State Medical Journal **2**: 2, 1953.

[2] "Practical Management of the Recalcitrant Tuberculosis Patient," Northrop, Fountain, and Zahn, United States Public Health Reports—Vol. **67**: 9, September 1952.

Clinic indicating P.R. had not kept out-patient appointments there. Further steps will be needed before this case can be closed.

Here is another: D.J.—white, male, fifty-seven years old, living with his wife and two small grandchildren, first became known to the Health Department through the Veterans Administration in 1934 for a moderately advanced active case of tuberculosis. Although the Health Department has worked with the man and his family since that time, it was not until 1950 that he was persuaded to re-enter a veterans' hospital for treatment, leaving shortly after. In 1952 after discussion with the local physician (who had not seen the man in several years and who agreed that something should be done) the health officer visited the man and learned that he would go back to a veterans' hospital but would like to go to one near home. The Veterans Administration Hospital was contacted, and it was learned that it would be six months before he could be admitted. Patch tests on the grandchildren at this time were negative. This man was an alcoholic who placed the burden of supporting the family on his wife. In June 1952 he was admitted to a state hospital from which he was discharged for disciplinary reasons.

About a week later he was brought into court where he agreed to go to a hospital. Authorities agreed to readmit him to an institution on the Western Shore. On the way to the hospital he stopped in Baltimore, became drunk and was sent home in a taxi by the Baltimore police with a $40 taxi bill for his wife.

He was again brought into court, sentenced to nine months in prison and placed in Jessups in a cell with another prisoner. In about two weeks he was transferred to the Maryland State Reformatory for Males which has a ward for tuberculosis patients. This ward is visited monthly by the Medical Director of the Maryland Tuberculosis Hospitals of the State Department of Health and appears to offer excellent care. In anticipation of D.J.'s return home the Section on Alcohol Studies of the State Health Department has been of great assistance in outlining an approach to this man's serious problem of alcoholism. It was planned to enlist the aid of the local constable, priest, and physician. The man refuses to recognize the fact that he is a problem drinker. He has evidenced no desire or intention of overcoming his defect.

Shortly before his discharge from prison it was learned that he wished to enter a veterans' hospital. A bed was available for him before his term was up. Since he could not be released except by the Governor commuting his sentence, an extension of the time of his admittance to the Veterans' Hospital was granted on the understanding that he would stay at least six months. It was learned he had "some important business" at home before he entered any hospital. A representative of the alcoholic studies group planned to meet him as he left prison to persuade him to go directly to the Veterans' Hospital. His family was not agreeable to this idea and expressed some resentment of "sending him to jail just because he had tuberculosis." He is now at home.

The third case is that of A.L.—white, male, thirty-seven years old, living with his wife and four small children. He came to the attention of the Health Department in 1948 with moderately advanced active tuberculosis. From the first he was reluctant to follow medical recommendations. He entered a hospital after the local Tuberculosis Association gave him $312 to pay some debts which he claimed prevented him from leaving home. He left the sanatorium against advice in a month because he had "nothing to do" while there. Numerous home visits were made by Health Department nurses both to arrange for his treatment with streptomycin while at home and to educate the family as to the seriousness of the situation and the desirability of his returning for care. Although cooperating with the Health Department in other respects, his wife has consistently refused to have an X-ray and never has had one.

Various things made the progress of his treatment unsatisfactory. On clinic days the "car broke down" or the children needed something and many other reasons were offered why he could not present himself. Assistance was arranged for the family and man through the Welfare Department. The condition at the end of 1948 was acute and the patient was very ill (with vomiting and severe malaise). He persisted in getting out of bed and "looking after the household." Early in 1949 he again entered the sanatorium. In two months he was feeling better and had gained weight. He absented himself against advice because no one had told him "how he was getting along." After being out two months, after many visits by the nurses, the man re-entered the sanatorium. He left within one month against advice because his wife was going to have another baby.

Debt and family responsibilities hung heavily on him. At best his condition would allow him only sporadic work. In 1951 he again entered the sanatorium. He left in three months on his own accord after he had been moved from a private room. During his stay he gained twenty-two pounds and was much improved. The children now all had positive patch tests. Steps were started to bring the family into juvenile court because of the exposure of the children. This was not carried through when the man promised to leave the home. This he did not do. In 1952, the patient developed laryngitis and was still working on and off while under the care of a local physician, receiving streptomycin and PAS. His own physician felt that A.L. should be in a hospital even by legal means if necessary.

The man was brought into court. He was represented by legal counsel who said that he was not getting a fee for the case, but was representing the man as a favor to some persons in the patient's town who wished to see that the man got a "fair shake." The patient did not seem to accept the fact that he was suffering from a dangerous infectious disease or that he was endangering the health of others by his present course of action. He was found guilty. Sentence was suspended if he would enter a hospital within two weeks. The lawyer arranged for him to enter the same clinic in Philadelphia in which R.P. was treated and also as an in-patient. At the time of this report the man is still in Philadelphia.

The last case concerns G.P.—male, white, fifty-one years old, living with his wife and 12 year old daughter. The man was first seen in the Health Department clinic in 1950. At this time he was under the care of the Philadelphia clinic mentioned earlier as an out-patient going periodically for treatment. His diagnosis was advanced, active bilateral tuberculosis with a consistently positive sputum. His tuberculosis was discovered while in a hospital in Delaware for a rectal fistula. There he was advised to go to a tuberculosis hospital. Instead he went to the clinic in Philadelphia where he could "go for a few days and return home." His wife and daughter have cooperated with the Health Department but the man has not followed the instructions of the Philadelphia clinic. He has continued to work and denied that the clinic had told him to limit his activities. He has also claimed that he had to provide for his family although his wife has been the real support since the onset of his illness.

A visit was made by the county health officer to the clinic in Philadelphia to discuss D.J., A.L., and G.P. It was pointed out that these men could not be allowed to violate Maryland law in spite of the fact that they were under medical supervision. The clinic management was forewarned that patients would be prosecuted when they were in violation.

The health officer also visited G.P. and explained the situation. He was told that it was not possible for him to continue exposing his daughter to his infection. He denied having contact with other people but it was learned that his five year old grandson also visited in the home. The patient refused to go to the hospital and since he lives about a quarter of a mile from Delaware, he asked if he could not be told when he was going to be arrested so that he might go over the state line. He was told he was free to move out of the state, but this could not be advised.

The man was brought into court, found guilty and the case continued to give the man an opportunity to enter a hospital.

A meeting was later held with the Chief of the Bureau of Tuberculosis of the Maryland State Health Department in an effort to develop better understanding of the operation of the sanatoriums and what they are doing.

The court was again asked to bring the man before it. The constable who was requested to get the man refused to do so stating "if the man is as dangerous as all that I'm not going to carry him in my car and expose myself to the disease. I have carried my last tuberculosis case."

The man was finally brought before the court and was directed to appear at the County Health Department to determine if he was infectious. A gastric washing was done and found to be microscopically positive. The man asked to be admitted to the Philadelphia clinic as an in-patient but he lacked funds. The local citizen who is a member of the clinic board was sent a letter asking if he could assist the man in this matter but no reply was received.

The magistrate was again asked to bring the man into court. G.P.'s wife then called stating the man was waiting for a bed at the Philadelphia clinic. The court on being informed of this asked to be kept further advised of his progress.

DISCUSSION

Legal aspects—The Maryland law states "any person who, while suffering from any dangerous infectious disorder, willfully exposes himself . . . without proper precautions . . . in any street (or) public place . . . shall be liable to a penalty not exceeding five hundred dollars or imprisonment not exceeding twelve months, or both, in the discretion of the circuit court for the county . . ."*

In order to be liable the individual must appear in a public place. If the four cases had stayed in their homes (no matter how many people were living with them or visiting them) there would be no basis for prosecution.

In order to establish the charge, the violator must be seen in public by a witness who will appear in court and swear that he was seen at the time which is required to be specified in the warrant.

In the first case, the neighbors were asked to be witnesses and although several of them had complained about the patient, none of them wanted to appear in court. Two women finally agreed to testify. Also at the time of the first trial it was not known that these witnesses had seen the man in a public place on the day charged. It developed that they had. In subsequent cases either a nurse or health officer arranged to see the individual in public before the warrant was issued.

In the first hearings the magistrate imposed sentence which was suspended pending suggested action on part of the patient. By so doing the case was closed. If the patient does not do as directed he must be charged in a new complaint.

Public reaction—Some of the most well-informed citizens of the community obviously do not comprehend the nature and seriousness of tuberculosis. The concept that an individual may be seriously ill and a threat to other people although he does not have pain or any marked signs of illness is evidently a difficult one for people to fully understand.

Evaluation—A great deal of time has been required to follow these four cases through the court. The final result with any one of them is not yet known. Further recourse to the court may be required.

At present, one case is hospitalized. Another case is in the process of being admitted. The other two are improved and at home. Of the latter, one may be more cooperative in the future and one will continue a problem until his drinking is checked. He is at this time no longer sputum positive.

The health officer has no choice except to protect the community and must follow these cases closely until they are no longer infectious.

R. H. Riley

Director

BALTIMORE CITY HEALTH DEPARTMENT

The Medical Care of Foster Children

Foster children, while they are wards of the Baltimore City Department of Public Welfare and living within the limits of the City of Baltimore, will receive health services and medical care through the Baltimore City Medical Care Program. The Program gives these children the following services when needed:

1. Physician services in his office
2. Physician services in the home of the foster parent
3. Complete medical examination
4. Consultation services of specialists
5. Treatment by specialists
6. Medicines and some medical supplies
7. Dental treatment
8. Eyeglasses.

Physician Services

Soon after a child has been accepted by a foster parent under the City Department of Public Welfare the parent will be asked by the Medical Care Clinic of the Baltimore City Hospitals to choose a physician for the child. The child then may be in good health. Usually the physician chosen by the foster parent will be the one who cares for other children living in the home.

---

* Md. Annotated Code, 1951, Art. 43, Sec. 57.

The physician selected and agreeing to accept responsibility for the child's care under the Baltimore City Medical Care Program will provide required medical services at his office and, when necessary, in the home of the foster parent. The physician should not be asked to visit the home unless the child is too ill to be taken to his office. The foster parent should be on the lookout for early symptoms of disease and the child should be taken to see the doctor without delay when his services are required but in order to properly conserve the doctor's time he should not receive calls from those who do not need his attention.

Drugs

If a child under the Baltimore City Medical Care Program needs medicine it can be obtained through a prescription written by the child's physician and filled at a drug store, usually nearby, selected by the foster parent. Some medical supplies, also, are available in this way.

Specialist and Hospital Services

If the physician chosen for the child requires advice or other assistance from a physician who has had special training and experience in the disease from which the child is suffering or if the services of a laboratory are required this assistance is available quickly and easily on the physician's request.

If the child's illness requires continued care in a hospital arrangements for admittance to the hospital should be made by a request from the attending physician directly to the admitting officer of the Baltimore City Hospitals. However, the Medical Care Clinic of that hospital will give assistance if its help is required to secure a hospital bed necessary for a foster child.

Identification Card

Soon after the child's physician has been selected, the foster parent will receive an identification card by mail from the Medical Care Clinic of the Baltimore City Hospitals. This card will bear the name of the child and the physician's name, address and telephone number. This card is valuable and should be kept safely. It should be presented to the physician whenever his services are required, to the druggist whenever a prescription for the child is filled and to the hospital when the child makes a visit there.

Regularly at the first of every quarter year (January 1, March 1, July 1 and October 1) the Medical Care Section of the Baltimore City Health Department will mail the child a new identification card as long as he remains eligible for services under the Baltimore City Medical Care Program. If an identification card is lost the foster parent promptly should telephone the Medical Care Clinic, Baltimore City Hospitals, requesting a replacement card.

Next to the physician chosen for the child the responsibility for his medical care rests with the Medical Care Clinic of the Baltimore City Hospitals. This clinic stands ready to provide any information which the foster parent may need regarding the Baltimore City Medical Care Program.

The telephone number of the Medical Care Clinic of the Baltimore City Hospitals is DIckens 2-5400, Extension 467.

Huntington Williams, M.D.

Commissioner of Health

State of Maryland Department of Health

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, October 30–November 26, 1953

																			DEATHS
	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	Influenza and pneumonia
	Total, 4 weeks																		
Local areas																			
Baltimore County	33	—	2	5	10	1	28	5	7	—	4	—	—	1	4	1	3	r-2	—
Anne Arundel	3	—	—	—	—	—	3	1	—	—	1	—	—	1	7	—	7	—	1
Howard	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	—
Harford	—	—	1	2	1	—	22	1	—	—	3	—	—	4	3	—	1	—	—
Carroll	—	—	—	1	—	—	1	—	—	—	1	—	—	—	—	—	1	—	1
Frederick	—	—	—	—	—	—	—	2	—	—	—	—	—	—	3	—	2	—	—
Washington	2	—	—	—	—	1	1	1	—	—	2	—	1	—	5	—	2	—	—
Allegany	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	—	—
Garrett	—	—	—	—	—	—	1	—	1	—	—	—	—	—	—	—	—	—	—
Montgomery	5	—	—	—	1	1	15	1	—	1	5	—	—	—	4	—	2	—	1
Prince George's	10	—	1	1	1	—	4	—	1	—	—	—	—	2	7	—	3	—	2
Calvert	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
Charles	1	—	—	—	—	—	—	—	—	—	1	—	—	—	2	—	1	—	—
Saint Mary's	2	—	—	—	—	—	—	—	—	—	—	—	1	—	2	—	1	—	—
Cecil	—	—	—	—	—	1	—	1	—	—	—	—	—	—	2	—	2	—	—
Kent	—	—	—	3	1	—	—	—	—	—	—	—	—	—	—	—	—	—	1
Queen Anne's	—	—	—	—	—	1	—	—	—	—	1	—	—	7	1	—	1	—	—
Caroline	1	—	—	—	—	—	1	—	—	—	3	—	—	—	1	—	2	—	—
Talbot	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Dorchester	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	16	—	—
Wicomico	—	—	—	—	43	—	—	—	—	—	—	—	—	—	5	—	7	—	1
Worcester	—	—	—	—	3	—	2	—	—	—	—	—	—	—	1	—	1	—	—
Somerset	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	—	—
Total Counties	59	0	4	12	60	5	78	12	9	1	21	0	2	15	52	1	56		8
Baltimore City	90	0	7	6	94	2	87	1	4	0	22	2	0	24	84	10	437		23
State																			
Oct. 30–Nov. 26, 1953	149	0	11	18	154	7	165	13	13	1	43	2	2	39	136	11	493		31
Same period 1952	158	5	9	24	39	3	68	31	27	0	68	1	1	22	179	12	635		37
5-year median	118	5	5	—	37	2	41	21		0	59	4	2	58	185	60	600		39
	Cumulative totals																		
State																			
Year 1953 to date	2899	11	1450	447	1708	73	2489	301	215	25	2267	31	12	375	2093	143	7172		636
Same period 1952	2917	13	849	222	9127	79	998	194	160	28	948	20	15	194	2426	176	6845		579
5-year median	3195	68	535	—	4050	63	1654	217		56	982	34	38	742	2488	784	6947		551

r = positive rabies reports in animals.

Blue Cross - Blue Shield

FINANCIAL STATEMENTS OF MARYLAND MEDICAL SERVICE, INC.

BALANCE SHEET

(As of September 30, 1953)

Assets

Cash on deposit	$309,035.98
Subscriptions & Accounts Receivable	199,526.05
Total Assets	$508,562.03

Liabilities and Reserves

Accounts Payable	$177,244.15
Reserves for Unreported and Pending Care	157,000.00
Unearned Subscription Charges	87,698.79
Reserve for Contingencies	86,619.09
Total Liabilities and Reserves	$508,562.03

Operating Statement

(9 months ended September 30, 1953)

Subscription Income	$1,243,535.64	100.0%
Medical Care for Subscribers	$1,054,259.92	84.8%
Balance after Medical Care	$ 189,275.72	15.2%
Administrative Expenses	$ 138,479.77	11.1%
Balance for Reserves	$ 50,795.95	4.1%

COMMENTS

While operations to date have resulted in an excess of income over expenditures, the funds that the Plan has thus far been able to set aside for reserves have not been wholly adequate in relation to established standards.

Reserves as of September 30 were sufficient for 1.31 months of average monthly expenditures (medical and administrative expense) as compared with 2.98 months average for 21 Blue Shield Plans in our size classification. However, experience has been improving and is expected to continue to improve as the Plan grows in size. There has been an increase of over 20,000 in membership since January 1, 1953.

R. H. DABNEY, *Director*

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. CHARLES H. WILLIAMS, *Auxiliary Editor*

MEMBERSHIP

MRS. MARTIN E. STROBEL

In order to institute and maintain a flourishing State Auxiliary, it is important to increase membership. It is hoped that this can be accomplished in three ways:

1. By organizing county medical auxiliaries where county societies exist.
2. By increasing and strengthening membership in existing auxiliaries.
3. By enrolling members-at-large.

It must be remembered that unorganized counties can be organized only with the consent of their County Medical Societies. These counties should study their special problems and enlist the help of the State Auxiliary in planning for the organizational meeting of the new counties. A sample Constitution and By-Laws of County Medical Auxiliaries can be obtained for use in organizing.

County auxiliaries that have already organized should invite eligible members in neighboring unorganized groups to their meetings as guests. It is important, however, to check the Medical Society roster for names *always*. Organized groups can also obtain the names of members-at-large in the State Auxiliary and invite them as guests to their meetings. One person can do much to effect organization in an unorganized county.

Membership in existing auxiliaries can be increased and strengthened in many ways, such as the following:

1. Check monthly with the Secretary of the Medical Society for names of the physicians who have become new members.
2. Give new members responsibility.
3. Hold meetings as regularly as possible.
4. Keep programs activated with many participating.
5. Work constructively and diligently to maintain membership interest.
6. Hold occasional joint meetings with the Medical Society and have fun together.

Each member of a county auxiliary must realize that it is our combined efforts that will assure others that we are qualified leaders in health. In order to be a good member, observe the following rules:

1. Attend auxiliary meetings regularly.
2. Participate in auxiliary activities—say "yes" when asked to serve. Remember you had a predecessor. Seek her cooperation and use her material.
3. Ask yourself as a member "What can I contribute?"
4. Learn to know others: be friendly and seek new friendships.
5. Enroll a new member.
6. Appreciate your privilege—others would enjoy what you regard as unimportant.
7. Activate people in your community to an appreciation of American medicine and our system of free enterprise. Contact your neighbors, club friends, business associates, and church members.

Above all, remember that a small Auxiliary is important. An Auxiliary member in a small group is almost an Auxiliary in her own right.

AUXILIARY PUBLIC SERVICE THE GATEWAY TO GOOD PUBLIC RELATIONS*

Fundamentals of a Good Public Service Program

First Step—Informed Membership

It is a fundamental truism that in order to solve a problem we must not only recognize and know the problem but we must learn the various steps and kind of action necessary for its solution. In order to act as an interpreter for the medical profession we must necessarily know the problems confronting the profession and the solutions offered by the profession. Therefore, complete and thorough self education is the first essential in facing and solving our problems.

---

* Reprinted from A.M.A. Woman's Auxiliary Public Relations Pamphlet, "The Medical Auxiliary and Public Service."

Second Step—Contacts

Every doctor's wife has contacts with other organizations which can and should provide valuable avenues for furthering good public relations. Auxiliary members as individuals participate in educational, civic and religious groups and in numerous health organizations. Auxiliary members have many daily contacts with community leaders. In the "extremely valuable" category are the contacts with public officials, educational personnel, leaders of civic, religious, patriotic, labor and farm organizations, and philanthropic and character building agencies. All of these relationships must be enlarged and extended. Through them our efforts can be multiplied a hundredfold, while without them progress will be almost imperceptible.

Third Step—Service

In order to develop good public relations every auxiliary must be a public service organization. Only through this media can we hope to achieve our ultimate goal. Paramount of course, must always be the question, "What can we do that will be of most service to our community in the field of health?"

Auxiliaries could and should utilize the work and enthusiasm of every doctor's wife in every organization and community project, in which she as an individual participates, and thus make the work and accomplishments of every doctor's wife, in every field of endeavor pay dividends to the professional family, to the auxiliary and mankind. Public relations has been defined as doing good. It will bring its own reward to us and the great humanitarian profession of medicine. Every auxiliary by careful inventory and planning could serve through its membership as a clearing house for community service. A check or report of the activities of individual members would provide enlightenment concerning many community projects and could furnish valuable resources and support for those activities and projects needing and deserving additional attention. In this manner auxiliaries could very shortly develop a reputation as a service organization, where other community service organizations could always find assistance for needed community projects and action. In this way the Medical Association's family would gain the complete confidence of the community and assume leadership and recognition for activities in the field of health and health education. Only by a sincere interest and participation in all civic problems affecting the community can we expect to assume our proper role in the field of health and leadership. By doing what any good citizen or neighbor could and should do we will meet our inherited and acquired responsibility "For A Better World;" by working together and thus be rightfully proud of the privilege of membership in the Woman's Auxiliary to the American Medical Association.

PUBLIC SERVICE IS EVERYBODY'S
BUSINESS AND "THE OBLIGATION IS OURS"

A.M.A. MAKES AVAILABLE FOUR TELEVISION SHOWS

People who attended the A.M.A. Public Relations Institute in Chicago last week were quite enthusiastic over the four new television shows which are being made available by the A.M.A. to state and county medical societies.

These films, earmarked for use by local medical societies only, were designed for airing on "public service time" over local TV stations. They will not be shown on any national TV network.

Each program deals with a different popular medical subject:

(1) "Operation Herbert"—a fast-moving, humorous play discussing medical care costs—stars well-known actor Jackie Kelk; (2) "A Citizen Participates"—documentary-type story tells about a town that needs a doctor and how one citizen heads a campaign to get one: (3) "What to Do"—series of six five-minute shows with ABC women's commentator Nancy Craig demonstrating how to use a thermometer, apply artificial respiration, stock a medi-

cine chest, and treat colds, abdominal pains and headaches, and (4) "Your Doctor"—Louis de Rochemont's film, now available for the first time on TV—describes medical training facilities today.

Prints of these new filmed TV shows may be obtained from the A.M.A.'s TV Film Library, 535 North Dearborn Street, Chicago 10, Ill. These shows must be booked well in advance of schedule date.

SUMMARY—MEMBERSHIP-ORGANIZATION-BULLETIN-TODAY'S HEALTH*

State	Component societies	County auxiliaries	Membership Med. & Chi. Faculty	A.M.A. membership	Auxiliary membership	Bulletin subscriptions	Today's health credits
Maryland	23	6	2,441	1,597	426	104	92

* A.M.A. Woman's Auxiliary Bulletin, Vol. 15, August, 1953.

Appreciation to the Woman's Auxiliary of the Baltimore City Medical Society Regarding the AMEF

Medical and Chirurgical Faculty of the State of Maryland
1211 CATHEDRAL STREET, BALTIMORE 1, MARYLAND

October 27, 1953

Mrs. Margaret Webster
President of the Woman's Auxiliary to the
Baltimore Medical Society
4336 North Charles Street
Baltimore 18, Maryland

Dear Mrs. Webster:

The American Medical Education Foundation of which I am State Chairman is most pleased to be the recipient of a very generous contribution from your fine organization.

We have received a check in the amount of five hundred dollars ($500.00) which will be forwarded immediately to our headquarters in Chicago. This contribution was only made possible through the almost heroic efforts of your Auxiliary in presenting the Faculty Ball at the Alcazar last spring, and by the cooperation in attendance from the members in component societies who are our good neighbors. I only hope that this great work will serve to underscore and strengthen the belief that you have already demonstrated on the part of the medical societies themselves in the necessity of maintaining an academic system of education free and unhampered by the necessity of federal subsidization.

Again, my deep and heart-felt thanks for your loyalty not only to this project, important as it is, but to the Medical Society behind whom you stand so strong.

Kindest regards,
Newland E. Day, M.D.
Chairman, Committee
to Cooperate With the A.M.E.F. of the
Medical and Chirurgical Faculty

COMING MEETINGS

OTOLARYNGOLOGICAL SECTION OF THE BALTIMORE CITY MEDICAL SOCIETY

C. Carleton Douglass, M.D., *Chairman* Albert Steiner, M.D., *Secretary*

Tuesday, January 12, 1954

Johns Hopkins Club, Homewood Campus

Cocktails 6:00 p.m. Dinner 6:30 p.m.

Surgical Approach to Head and Neck Cancer in Man. Robert Smith, M.D., Chief of Surgery, National Cancer Institute. (By invitation.)

Discussion by Grant E. Ward, M.D.

BALTIMORE CITY MEDICAL SOCIETY

Osler Hall, 1211 Cathedral Street

Friday, January 15, 1954, 8:30 p.m.

Regional Enteritis. Burrill B. Crohn, M.D., Consultant Gastroenterologist, Mount Sinai Hospital, New York City, and Consultant Gastroenterologist, Columbia University College of Physicians and Surgeons, Postgraduate Medicine, New York City. (Illustrated.) (By invitation.)

Chronic Idiopathic Ulcerative Colitis—Problems in Etiology and Management. Thomas E. Machella, M.D., F.A.C.P., Chief, Gastrointestinal Clinic, Hospital of the University of Pennsylvania, and Associate Professor of Medicine, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania. (Illustrated.) (By invitation.)

Question Period.

ANESTHESIA STUDY COMMITTEE

Faculty Building, 1211 Cathedral Street, Baltimore

Wednesday, January 20, 1954, 8:30 p.m.

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the Baltimore City Health Department

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Faculty Building, 1211 Cathedral Street, Baltimore

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty

Richard W. TeLinde, M.D., *Chairman* Beverley C. Compton, M.D., *Secretary*

Thursday, January 21, 1954, 5:00 to 6:00 p.m.

MATERNAL MORTALITY COMMITTEE

Faculty Building, 1211 Cathedral Street, Baltimore

Thursday, January 28, 1954, 4:00 p.m.

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and the Baltimore City Health Department

MARK THESE DATES ON YOUR
CALENDAR NOW
AND PLAN TO ATTEND

The Annual Meeting

of the Medical and Chirurgical Faculty

✶

TUESDAY, APRIL 27, 1954

AND

WEDNESDAY, APRIL 28, 1954

Business Meetings, MONDAY, APRIL 26, 1954

Faculty Ball, MONDAY EVENING, APRIL 26, 1954

INDEX TO MARYLAND STATE MEDICAL JOURNAL*

VOLUME 2, 1953

Abbott, Osler A.: Recent advances in surgery of the autonomic nervous system. (J. M. T. Finney fund lectureship), 3–24
Abdomen, acute (Thorek), 355–63
Aberdeen proving ground needs medical officer and industrial surgeon, 91
Adoption law of Maryland
  important notice relative to (Anderson), 115–6
  symposium
    announced, 37
    proceedings, 573–88
Allegany-Garrett County Medical Society, 92–3, 147, 201, 334, 383–4, 510–1, 561–2, 610, 651
  Members, 262–3
  Officers, 147
Alpert, Louis K.: The collagen disorders, 301–6
American Academy of General Practitioners, 525
American College of Surgeons
  scholarships, 572
  sectional meeting, 621
American Heart Association, annual meeting, 1954, 525
American Medical Association
  annual meeting, 170, 207
  offers two new exhibits, 392
  publishes "How to get a doctor," 392
American Medical Association. Bureau of Exhibits
  new exhibits ready for showing, 426
American Medical Association. Committee on Medical Motion pictures, 386
American Medical Education Foundation
  committee to cooperate with (Day), 299–300
  contribution from the Woman's Auxiliaries, 146, 626
  educational campaign, 220
American Red Cross. Baltimore chapter needs part-time physicians, 210
Anderson, G. C. A.:
  Important notice relative to adoption law, 115–6
  Legal aspects of the adoption law, 580–3
Andrus, E. Cowles: Cardiac diets, 180–1
Anemia, Iron deficiency (Wagley), 351–5
Aneurysms, aortic, Excision of (Bahnson), 537–46
Angiocardiography (Dotter), 641–3
Anne Arundel County Medical Society, 38, 147, 249
  Members, 263–264
Anne Arundel General Hospital, new wing, 38
Annuities, proposal to provide tax deferments on amounts used for, 213–4
Antibiotics in skin diseases (Zeligman), 647–50
Aortic aneurysms, Excision of (Bahnson), 537–46
Aortography (Peirce), 635–40
Armed forces, see U. S. Armed forces
Armed Forces Institute of Pathology, 655
Arnold, James G., jt. auth., see Miller, Joseph M.
Arthritis
  and rheumatism (Klinefelter), 508–9
  books on (Krause), 656–7
Automobile accidents, safety campaign movie, 221
Autopsy law of Maryland, 478
Awards
  National Science Foundation, 650
  Passano Foundation, 348

Bahnson, Henry T.: Excision of aortic aneurysms, 537–46
Baker, J. Tyler: Prophylactic sterilization of the female, 483–4
Baldwin, Ruth W.: The dione drugs in petit mal seizures, 601–9
Ball, Mrs. John G.
  Address of the incoming president (Woman's Auxiliary), 344
  Conference highlights, 52–3
  Montgomery County General Hospital supper and bazaar, 163–4
  President's message, 570–1
Baltimore chapter, American Red Cross, needs part-time physicians, 210
Baltimore City Dental Society (Eskow), 106, 346
Baltimore City Department of Education, needs secondary school physicians, 560
Baltimore City Health Department
  Anesthesia joint study group, 621, 669
  Birth and death certificates, 339
  Certificates of live birth, form revised, 157–8
  Decline in tuberculosis mortality, 614
  Medical care of foster children, 662–3
  Reporting of occupational diseases, 99
Baltimore City Medical Society, 201–2, 249, 384–5, 511, 562–3, 610, 652–3, 669
  Anesthesia joint study group, 621
  Anesthesiology section, 222
  announces seminar on "Recent advances in radiological studies of the vascular system," 93
  announces symposium on diabetes, 39
  annual meeting, announcement, 622
  Annual report of chairman (Phillips), 148–9
  Cancer section, 93, 94–5, 249–50, 622, 653
  course in electro-cardiography under auspices of, 119
  Dermatological section, 563
  given projector and screen by Charles P. McCormick, 2
  Maternal Mortality Committee, 563, 622, 669
  Medical Section, 222
  meeting with the Heart Association of Maryland, 562
  Members, 264–281
  officers and committees, 1953, 147–8
  Ophthalmology section, 93
  Otolaryngology section, 562, 669
  panel discussion on "Diets," 171–89
  Radiological section, 95
  role in reorganization of Doctors' Hospital (Schuman), 217–9

---

* Index compiled by the Library Staff of the Medical and Chirurgical Faculty.

  Section on diseases of the chest, 562
  Section on internal medicine, 481
  Surgical section, 39
  symposium on diabetes, 363–77
Baltimore County Medical Society, 95-6, 149, 610
  Act of incorporation, 202–3
  Members, 281–3
  New directory, 350
  Nominating committee report, 96
Baltimore County plan of the Woman's Auxiliary (Strobel), 163
Baltimore study of chronic illness (Roberts), 297–9
Baltimore, Tuberculosis problem in, symposium, 58–87
Barnwell, John T., moderator, symposium on tuberculosis, 58–87
Barr, David P., to speak at University Hospital, 149
Bauer, Louis H., to speak at Auxiliary luncheon, 161
Baumgartner, E. Irving: Letter to the editor, 526
Beall, Ira Washington, 512–14
Beard, J. Howard: Letter to the editor, 526
Beck, Harvey Grant Memorial Lecture see Medical and Chirurgical Faculty. Transactions
Beck, Harvey Grant, presentation of volume of his writings (Wise), 529
Bennett, Van B., jt. auth., see Morrison, Samuel
Berge, Mrs. Henry, 98
Berthrong, Morgan, jt. auth., see Wainwright, Charles W.
Bibliography: Recent publications by faculty members, 42–4, 150–2, 336–8
Biopsy, relation to diagnosis (Wagner), 349–50
Birth certificate revised, 157–8
Bladder, Role of the physician in the early detection of cancer of (Jewett), 165–6
Blalock, Alfred, to speak at World Medical Association Conference, 99
Blue Cross and Blue Shield
  and the employer, 101
  and the nation (Dabney), 51
  Blue Shield philosophy (Dabney), 343
  continue to grow (Dabney), 569
  doctor is the key to, 617
  enrollment period for Faculty members and employees, 527–8
  enrollment regulations, 616
  history of (Dabney), 519
  "indemnity" or "service" (Christenson), 101–3
  inter-plan service benefit bank (Dabney), 390
  letter relating to (Johnson), 258
  Maryland Hospital Service, Inc. (Dabney), 209–10
  Maryland Medical Service, Inc., report of Board of Trustees (Jewett), 391–2
  Rate increase, 257
  Safeguarding (Dabney), 160
  Your decision and (Dabney), 257
Blue Shield see Blue Cross and Blue Shield
Boas, George: The sanctity of life, 128–31
Bodian, David: Current views on poliomyelitis, 598–601
Bone bank (Reeves), 495–7
Brackin, John T., Jr., jt. auth., see Miller, Joseph M.
Brantigan, Otto C.: Surgical approach in the treatment of pulmonary tuberculosis, 228–36
Browne, J. S. L.: The changing nature of medicine, 626–34 (I. Ridgeway Trimble Lectureship)

Calvert County Hospital, 385, 512
Calvert County Medical Society, election of officers, 38, Members, 283
Cancer of the bladder, Role of the physician in the early detection of (Jewett), 165–6
Cancer research and therapy, Present trends (Figge), 510–11
Capitol Clinic, A.M.A., excerpts from
  Magnuson report goes to the printers, 54
  Red Cross assumes cost of producing Gamma globulin, 49
Caples, Mrs. D. D.: First future nurses convention, 520–1
Cardiac diets (Andrus), 180–1
Cardiac surgery, prize offered for essay on, 494
Carey, T. Nelson, and Warner, C. Gardner: Clinical pathological conference, 33–7
Caroline County Medical Society, 250–1
  Members, 283
Carroll County Medical Society, 96, 251, 334, 385–6, 611
  Members, 283
Caution, Gustave Orville, 167–170
Cecil County Medical Society, members, 283–4
Charles County Medical Society, members, 284
Chase, Walter M.: Letter to the Editor, 260
Chesney, Alan M.: Word of appreciation to our editor, 1
Child placement agencies, Maryland, 116
Children, law governing adoption, 115–6
  vaccination and immunization history of (Hayman), 141–3
Christensen, Osborne D.: Blue Cross, Blue Shield, "indemnity" or "service," 101–3
Chronic illness, Baltimore study of (Roberts), 297–9
Civil defense, volunteer yourself, 221
Clinical pathology conference (Carey), 33–37
Clinical pathology conference (Wainwright), 189–200
Collagen disorders (Alpert), 301–6
Commercial exhibitors, annual meeting of Faculty, 478
Component medical societies of Faculty, officers and delegates, 475
Compton, Beverley C.: Your annual meeting, 56–7
Convalescence and later life after coronary thrombosis (Love), 589–93
Convalescent homes in the medical care program, 45–9
Cook, Mrs. E. Ellsworth: Our first party, 104–5, 164
Coronary thrombosis, convalescence and later life (Love), 589–93
County medical care program, a report on (Riley), 517
Cowley, R Adams: The treatment of pulmonary abscess, 593–5
Creative Arts Show, annual meeting, 477–8
Cystic fibrosis of the pancreas (Gibbs), 644–7

Dabney, Reginald H.: Blue Cross and Blue Shield continue to grow, 569
  Blue Cross and the nation, 51
  Blue Cross Inter-plan service benefit bank, 390
  Blue Shield philosophy, 343
  Employer and Blue Cross-Blue Shield, 101

  Enrollment regulations for Blue Shield, 616
  History of Blue Cross, a national health plan, 519
  Maryland Hospital Service, Inc., annual report, 209–10
  Safeguarding Blue Cross, 160
  Your decision and Blue Cross, 257
Daley, Allen: Relative position of the specialist, the general practitioner and the public health officer in Britain, 24–33
Danowski, T. S.: Interrelations of thyroid and iodine metabolism, 530–7 (Harvey Grant Beck Memorial Lecture)
Daugherty, Leslie E.: Responsibility, 107–8
Davis, Mrs. Shelley: How to work with women's clubs, 618–9
Day, Newland E.: Committee to cooperate with American Medical Education Foundation, 299–300, 454–5
Deaths associated with pregnancy to be reported, 563
Defense department's Doctor Draft Bill to be introduced, 345
Defense department proposes regroupings in doctor draft, 204
Dermatology, diet in (Robinson), 178–9
Diabetes, symposium on, 363–77
  Announced, 39
  Diabetic emergencies; pre- and postoperative treatment (Jones), 368–74
  General management (Eastland), 363–6
  Juvenile diabetes (Guild), 366–8
  Peripheral vascular disturbances (Yeager), 375–7
Diagnosis, relationship of biopsy to (Wagner), 349–50
Diamond Anniversary of Medical Progress, 57
Diehl, William K., jt. auth., see Hundley, J. Mason, Jr.
Diets; panel discussion, 171–89
Dione drugs in petit mal seizures (Baldwin), 601–9
Doctor draft, 204, 345, 348
  Defense department issues directive on, 655
  dual registrants have 30 days to ask commission, 650
Doctor Draft Act, 221
Doctor Draft Bill, Defense Department, 345
Doctor Draft Law, as revised 1953, 480–1, first contest, 609
Doctor's Day (Levan), 162–3
Doctors' Hospital, reorganization and approval of (Schuman), 217–9
Dooley, Myrtle: Nursing vs. nurses, 68–70
Dorchester County Medical Society, 38, 563
  Members, 284
  new members, 38
Dotter, Charles T., and Steinberg, Israel: Angiocardiography, 641–3
Dropsy, books on (Krause), 612–3
Drugs and cosmetics, symposium on use and abuse of, announced, 222
Drugs, legislation (Kantner), 346–7
Due, Paul F., moderator, symposium on trauma, 306–28

Eastland, J. Sheldon: General management (diabetes), 363–6
Eastman, Nicholson J.: Obstetrics (diet in), 176–7
Eastman, Nicholson J., to speak at World Medical Association conference, 99
Ebeling, William Carl, jt. auth., see Morrison, Samuel
Editorials
  Gynecology in general practice (Novak), 223–6
  Keeping up with advances in medicine (Walker), 55–6
  Relationship of biopsy to diagnosis (Wagner), 349–50
  Responsibility (Daugherty), 107–8
  Word of appreciation to our editor (Chesney), 1
Electrocardiography, course in, Baltimore City Medical Society, 119
Endocrine disorders, laboratory tests in (Wiswell), 497–503
Epilepsy, books on, in Faculty Library, 565–6
Eskow, A. Bernard: Baltimore City Dental Society, 106, 346
Esophageal varices, bleeding, and their surgical treatment (Linton), 400–11
Euthanasia, symposium on, 120–40
"Evening in Paris" ball, announcement, 106, 164
Exhibits, new A.M.A., ready for showing, 426

Faculty facts (Kirkman), 293–6
Family spending for medical care, 219
Federal scholarships proposed for medical students, 528
Fibroblastoma, hourglass perineural on the cervical part of the vertebral column (Miller), 87–9
Figge, Frank H. J.: Present trends in cancer research and therapy (a summary), 510–11
Finney, John M. T., Lecture, see Medical and Chirurgical Faculty of Maryland. Transactions
Fisher, Russell S.: Viewpoint of the pathologist, trauma, 307–9
Fleming, Charles M.: Letter to Dr. Charles H. Williams, 149
Fort, Wetherbee: Expression of gratitude to Charles P. McCormick, 2
Foss, Noel E.: Pharmaceutical aspects of prescription writing, 595–8
Foster children, medical care, 662–3
Frederick County Medical Society, 512–514, 653–4, Members, 284–5
Future nurses convention (Caples), 520–1
Future Nurses of Maryland, 259

Gamma globulin for measles and hepatitis, 634
Gamma globulin, Red Cross assumes cost of producing, 49
Gamma globulin distribution, Maryland state plan, 339–41
Gamma globulin distribution, O.D.M. to handle, 210
Gastro-intestinal bleeding, and hypertension, reciprocal relationships (Morrison), 328–33
General practice, gynecology in (Novak), 223–6
General practice, psychosomatic medicine in (Knotts), 89–91
Geriatrics, books on old age in Faculty library, 254–5
Gibbs, Gordon E.: Cystic fibrosis of the pancreas 644–7
Glover, Robert P.: The indications for and the results of surgery for mitral and aortic stenosis, 547–54
Gout, books on, in the Faculty library, 387–8
Great Britain, medical practice in, 24–33
Guild, Harriet G.: Juvenile diabetes, 366–8
"Gus," honoring "Our Gus," 167–70
Gynecological problems, diagnosis and management of (Reich), 241–4
Gynecology in general practice (Novak), 223–6

Harford County Medical Society, 96–7
  election of officers for 1953, 97
  Members, 285

Hayman, Charles R.: Vaccination and immunization history of children entering first grade in 1951 and 1952, 141–3

Head injury, traumatic unconsciousness in (Thompson), 143–6

Headache, nicotinic acid therapy in vasoconstrictive type (Morgan), 377–82

Health insurance council, 97

Heart Association of Maryland
  meeting with Baltimore City Medical Society, 562
  spring scientific assembly, 216–7

Heart traineeships, 158

Heatherington, Leon H.: Hospitalization vs. home care in tuberculosis, 64–7

Henson, Mrs. Anita: Public health nurse in tuberculosis control, 63–4

Hepatitis rate, among U. S. troops, 200

Hightower, John A., jt. auth., see Woodward, Theodore E.

Hollins, Myrtle, 566

Hospital in-patient program in Maryland (Notkin), 153–7

Hourglass perineural fibroblastoma on the cervical part of the vertebral column (Miller), 87–9

Howard, John Eager: Obesity, 172–6

Howard County Medical Society, Members, 285

Hundley, J. Mason, Jr.; Diehl, William K., and Kardash, Theodore: The treatment of benign uterine bleeding with intra-cavitary radiation, 504–8

Hypertension (Mann), 181–2

Hypertension and gastro-intestinal bleeding, reciprocal relationship (Morrison), 328–33

Illinois University School of Medicine, annual assembly in otolaryngology, 258

Immunization history of children entering first grade in 1951 and 1952 (Hayman), 141–3

Income tax, bill to allow deductions for professional education, 333

Industrial physicians and nurses, conference on rheumatic disorders in industry, 473

Internist, viewpoint of, in trauma (Lilienthal), 309–12

Intra-cavitary radiation, use in benign uterine bleeding (Hundley), 504–8

Iodine metabolism, interrelations of thyroid and (Danowski), 530–7

Iron deficiency anemia (Wagley), 351–5

Jewett, Hugh J.: Report for the Board of Trustees of Maryland Medical Service, Inc., 391–2
  Role of the physician in the early detection of cancer of the bladder, 165–6

Johnson, Marius P.: Letter relating to Blue Cross-Blue Shield, 258

Jones, Benjamin F.: Diabetic emergencies; pre- and post-operative treatment, 368–74

Jones, Georgeanna Seegar: Medical aspects, adoption law, 574–7

Kantner, L. M.:
  Let's bring it out in the open, 620–1
  Maryland Board of Pharmacy, legislation, 346–7
  Maryland Pharmaceutical Association, 397

Kardash, Theodore, jt. auth., see Hundley, J. Mason, Jr.

Keefer, Chester S., sworn in as Special Assistant to the Secretary of Health, Education and Welfare, 611

Kent County Medical Society, Members, 285

Kirkman, Walter N.: Faculty facts, 293–6

Klinefelter, Harry F.: Arthritis and rheumatism, 508–9

Knotts, E. Paul: Psychosomatic medicine in general practice, 89–91

Kohler, Mrs. Eleanor, 566

Kolson, Dr. Jack W., Memorial Lecture, Sinai Hospital, announced, 97

Krag, Cletus L.: The nursing and convalescent home in the community's total medical care program, 45–9

Krause, Louis:
  Books on arthritis, 656–7
  Books on dropsy, 612–3
  Books on epilepsy, 565–6
  Books on gout, 387–8
  Books on old age, 254–5
  Medical aspects relating to euthanasia, 131–6

Laboratory tests in common endocrine disorders (Wiswell), 497–503

Langeluttig, H. Vernon: The teaching of tuberculosis in the medical school, 75–7

Lawyer and jurist, viewpoint of, trauma (Niles), 316–9

Legal aspects of the adoption law (Anderson), 580–3

Legal aspects relating to euthanasia (Orth), 120–7

Legal procedures in tuberculosis control (Riley), 659–662

Legislation to provide tax deferments on amounts used for annuities, 213–4

Leptospirosis, the protean clinical features of (Woodward), 486–9

Letters to the editor, 260, 526

Levan, Mrs. Gerald W.: Doctor's day, 162–3

Librarians, medical, regional meeting, 254

Life, sanctity of (Boas), 128–31

Lilienthal, Joseph L.: Viewpoint of the internist, trauma, 309–12

Linton, Robert R.: Bleeding esophageal varices and their surgical treatment, 400–11 (Finney Fund Lecture)

Live birth, certificate revised, 157–8

Love, William S.: Management of convalescence and later life after coronary thrombosis, 589–93

McCormick, Charles P.,
  An expression of gratitude to (Fort), 2
  Gives projectors and screen to Baltimore City Medical Society, 2
  Thank you, Mr. McCormick (Yeager), 2

MacLeod, Colin M.: Etiological considerations and the prevention of rheumatic fever, 236–41

Mann, George V.: Hypertension, 181–2
  moderator, panel discussion: diets, 171–89

Marriott, Henry J. L., becomes consultant to editorial department of Williams & Wilkins Co., 97

Maryland Academy of General Practice, 215–216

  - Fifth annual scientific assembly, 523–4
  - Joint meeting with District of Columbia Academy, 217
  - Members honored, 524
  - Membership committee, 217
  - Membership requirements, 525
  - New members, 217, 524
  - Officers, 523
- Maryland adoption law,
  - important notice (Anderson), 115–6
  - symposium on, 573–88
- Maryland Board of Medical Examiners, 426, 440–1
  - Examinations, 441
  - Meetings, 441
  - Reciprocity, 441
- Maryland Board of Pharmacy (Kantner), Legislation, 346–7
- Maryland hospital inpatient program (Notkin), 153–7
- Maryland Hospital Service, Inc. (Dabney), 209–10
  - see also Blue Cross and Blue Shield
- Maryland Medical Service, Inc., financial statement, 665
- Maryland Medical Service, Inc., report for Board of Trustees (Jewett), 391–2
  - see also Blue Cross and Blue Shield
- Maryland Pharmaceutical Association (Kantner), 397
- Maryland Radiological Society, Officers, 546
- Maryland State Board of Examiners of Nurses, annual report, 211–3
- Maryland State Department of Health
  - Monthly communicable disease report, 50, 100, 159, 208, 256, 342, 389, 479, 518, 568, 615, 664
  - Plan for distribution of Gamma Globulin, 339–41
  - Report on the functioning of the county medical care program, 517
- Maryland State Nurses Association, 161
- Medical and Chirurgical Faculty of Maryland
  - Annual meeting, announcements, 44, 56–7, 109–13, commercial exhibitors, 478
  - Committee for the study of Pelvic Cancer, 563, 622 629
  - Committee to cooperate with American Medical Education Foundation (Day), 299–300
  - Committees, 1953, 117–9, 474–5
  - Constitution, amendments to, 457–60
  - Creative Arts Show, 477–8
  - Faculty Ball, annual meeting, 1953, 161, chairmen of committees, 114
  - Faculty facts (Kirkman), 293–6
  - Honoring "Our Gus," 167–170
  - Library
    - Books on arthritis in, 656–7
    - Books on dropsy in, 612–3
    - Books on epilepsy in, 565–6
    - Books on gout in, 387–8
    - Books on old age in, 255
    - John Ruhräh Fund, 205–7
    - Library and Finney Fund Committee report, 442–5
    - Medical Library association meeting, 515
    - New appointments, 98, 566
    - Publications recently added to the library, 98, 515–6, 566–7, 657
    - Resignation, 566
    - Seliger collection, 612
    - Visitors from overseas, 515
    - Walter Ralph Steiner Memorial Collection, 40–1
  - Members, 261–91
  - Members and employees, Blue Cross-Blue Shield enrollment, 527–8
  - Officers and delegates of component medical societies, 475–7
  - Officers, personnel of committees, 474–5
  - Publications by members, 42–4, 150–2, 336–8
  - Semi-annual meeting, 1953, announcements, 411, 482
- Medical and Chirurgical Faculty of Maryland. Transactions, 1952
  - Annual meeting, 1952
    - Address: Relative position of the specialist, the general practitioner and the public health officer in Britain (Daley), 24–33
    - Clinical pathology conference, 33–7, 189–200
    - John M. T. Finney Fund Lecture: Recent advances in surgery of the autonomic nervous system (Abbott), 3–24
    - Symposium on the tuberculosis problem in Baltimore—past, present, and future, 58–87
  - Semi-annual meeting, 1952
    - Business sessions, 412–4
    - Program, 446–8
    - Reports
      - Advisory committee to the State Health Department, 414–7
      - Council on medical care, 418–19
      - Maryland Hospital Service, Inc. and Maryland Medical Service, 414
      - Resolutions committee, 417–8
- Medical and Chirurgical Faculty of Maryland. Transactions, 1953
  - Annual meeting, 1953
    - Election of State Board of Medical examiners, 426
    - Harvey Grant Beck Memorial Lecture: Interrelations of thyroid and iodine metabolism (Danowski), 530–7
    - House of Delegates, 419–26, 427–73
    - I. Ridgeway Trimble Lectureship: The changing nature of medicine (Browne), 626–34
    - John M. T. Finney Fund Lecture: Bleeding esophageal varices and their surgical treatment (Linton), 400–11
    - Members, 261–291
    - Remarks by President of Woman's Auxiliary, 623–4
    - Reports
      - Advisory committee to State Health Department, 471
      - Advisory committee to the Woman's Auxiliary, 472
      - Army Medical Library Committee, 455
      - Blood bank advisory committee, 455–6
      - Board of Medical Examiners, 440–1
      - Board of trustees of Maryland Medical Service, Inc., 472–3
      - Cancer committee, 456–7
      - Committee for better distribution of doctors throughout the state, 451

    Committee for the study of certain phases of medical economics, 453–4
    Committee for the study of pelvic cancer, 467
    Committee on constitution and by-laws, 457–60
    Committee on industrial health, 461–2
    Committee on Medical Research, 464
    Committee on National Emergency Medical Service, 466
    Committee on public instruction, 469
    Committee on rural medicine, 470
    Committee on scientific work and arrangements, 446
    Committee to advise the State Accident Fund, 471–2
    Committee to consider the relationship between hospitals and specialties and the manner of payment for professional services, 470
    Committee to cooperate with the American Medical Education Foundation, 454–5
    Committee to study an insurance problem, 452–3
    Committee to study legislative and professional standards and staff relations of hospitals, 451
    Committee with the Bar Association on medicolegal problems, 464–5
    Council report, 437–9
    Curator's, 449
    Delegates to A.M.A., 439–40
    Diabetic detection committee, 461
    Editor, Maryland State Medical Journal, 448–9
    Eugene Fauntleroy Cordell Fund Committee, 461
    Geriatrics committee, 461
    Legislative committee, 462–3
    Library and Finney Fund committee, 442–5
    Maternal and child welfare committee, 463–4
    Medical Advisory committee to Selective Service, 449–50
    Memoir committee, 465–6
    Mental Hygiene Committee, 466
    New building committee, 466–7
      Subcommittee on building plans, 467
      Subcommittee on finance, 466–7
    Physiotherapy committee, 467
    Postgraduate educational committee, 467–9
    Professional conduct committee, 448
    Resolutions committee, 423–4
    Scientific speakers bureau, 470–1
    Secretary's, 427–8
    State Practice Act, 441
    Treasurer's, 428–437
    Tuberculosis committee, 472
  Testimonial to Dr. Harvey B. Stone, 624–6
Medical and Chirurgical Faculty of Maryland. Woman's Auxiliary, see Woman's Auxiliary
Medical and Dental Academy, U. S., 166
Medical aspects, adoption law (Jones), 574–7
Medical aspects relating to euthanasia (Krause), 131–6
Medical care
  average family spending for, 219
  free for U. S. personnel, 613
  of foster children, 662–3
Medical care program, nursing and convalescent home in the (Krag), 45–9
Medical director of Board of Education, New York City, position open, 210
Medical librarians regional meeting, 254
Medical Library Association, 515
Medical officer needed at Aberdeen Proving Ground, 91
Medical officers, survey of Armed Forces, 333
Medical orientation conferences, 2nd. Army area, 103
Medical practice in Great Britain, 24–33
Medical students, Federal scholarships proposed for, 528
Medicine
  changing nature of (Browne), 626–34
  keeping up with (Walker), 55–6
Metabolism, interrelations of thyroid and iodine (Danowski), 530–7
Meyer, Eugene E.: Viewpoint of the psychiatrist (trauma), 312–5
Military pathologists, 655
Military service, extra pay issue, 99
Military service, physicians, 204
Miller, Joseph M.; Arnold, James G.; and Brackin, John T., Jr.: Hourglass perineural fibroblastoma on the cervical part of the vertebral column, 87–9
Miller, Victor D., 203
Montgomery County General Hospital, 163–4
Montgomery County Medical Society, Members, 285–7
Morgan, Zachariah R.: Nicotinic acid therapy in vasoconstrictive type of headache, 377–82
Morrison, Samuel; Ebeling, William Carl; and Bennett, Van B.: A study on the reciprocal relationship of hypertension and gastro-intestinal bleeding, 328–33
Moser, Herman, moderator, symposium on adoption law of Maryland, 573–88
Mt. Pleasant Hospital, 564
Murray, F. A. G., 383–4

National Cancer Institute host to Baltimore City Medical Society, 249–50
National Emergency Medical Service, Council on, surveys former medical officers, 333
National Heart Institute, heart traineeships, 158
National Science Foundation awards, 650
Nervous system, recent advances in surgery of the autonomic (Abbott), 3–24
New York Board of Education needs medical director, 210
Nicotinic acid therapy in vasoconstrictive type of headache (Morgan), 377–82
Niles, Emory H.: Viewpoint of the lawyer and jurist (trauma), 316–9
Non-operative treatment of stress incontinence in women (Wharton), 555–60
Notkin, Herbert: The hospital inpatient program, 153–7
Novak, Emil: Gynecology in general practice, 223–6
Nurse recruitment film, Woman's Auxiliary, 571–2
Nurse recruitment program of the Woman's Auxiliary, 52–3
Nurses
  Annual report of Maryland State Board of Examiners, 211–3
  First future nurses convention, 520–1
  Future Nurses of Maryland, 259
  Student nurses admitted to state schools, 572
Nursing homes in the medical care program, 45–9

Nursing scholarship awarded by Woman's Auxiliary to the Baltimore County Medical Society, 571
Nursing scholarship to be established by the Woman's Auxiliary, 161
Nutrition, parenteral (Waddell), 244–8

Obesity (Howard), 172–6
Obstetrics, diet in (Eastman), 176–7
Office of Defense Mobilization, to handle Gamma Globulin distribution, 210
Orth, Charles E.: Legal aspects relating to euthanasia, 120–7
Old age, books on, 254–5
Otolarnygology, annual assembly, University of Illinois, 258
Owens, Charles L., 92

Pan American Medical Women's Alliance, fourth congress, 426
Pancreas, cystic fibrosis (Gibbs), 644–7
Parenteral nutrition (Waddell), 244–8
Parke, Davis and Company, advertising policy, 260
Passano Foundation award, 1953, 348
Pathologist, viewpoint of, trauma (Fisher), 307–9
Pathologists, military, 655
Pathology, clinical conference (Carey), 33–7, (Wainwright), 189–200
Pediatric seminar, second annual, announcement and schedule, 105
Peirce, E. Converse: Aortography, 635–40
Pension plans, voluntary, 213–4
Peripheral vascular disturbances (Yeager), 375–7
Petit mal seizures, dione drugs in (Baldwin), 601–9
Pharmaceutical aspects of prescription writing (Foss), 595–8
Phillips, Otto C.: Annual report, Anesthesiology section, Baltimore City Medical Society, 148–9
Physicians, military service, 204, 221
  see also Doctor Draft
Physicians needed in Baltimore schools, 560
Pincoffs, Maurice C., appoints committees for 1953, 117–9
Poliomyelitis, current views (Bodian), 598–601
Postgraduate lecture course, University of Maryland School of Medicine, 398
Postgraduate study requirements for Maryland Academy of General Practice, 215
Pregnancy, deaths associated with, 563
Prescription writing, pharmaceutical aspects (Foss), 595–8
Prescriptions, substitutions (Kantner), 620–1
President's Commission on the Health Needs of the Nation, 54
Prince George's County Medical Society, 334–5, 386, 611, 653
  Members, 287–9
Professional education, bill to allow income tax deductions for, 333
Psychiatrist, viewpoint of, trauma (Meyer), 312–5
Psychosomatic medicine in general practice (Knotts), 89–91
Pulmonary abscess, treatment (Cowley), 593–5

Queen Anne's County Medical Society
  Election of officers, 38–9
  Members, 289

Racusin, Nathan: Tuberculosis as seen by the general practitioner, 62
Radiological studies of the vascular system, seminar, 635–43
Red Cross, assumes cost of producing Gamma Globulin, 49
Reeves, Henry G.: Bone banks, 495–7
Riggs Cottage Sanitarium, 653–4
Reich, Jerome B., jt. auth., see Reich, Walter J.
Reich, Walter J.; Rubenstein, M. William; and Reich, Jerome B.: Diagnosis and management of common gynecological problems, 241–244
Responsibility (Daugherty), 107–8
Rheumatic diseases in industry, conference, 473
Rheumatic fever, etiological considerations and the prevention of (MacLeod), 236–41
Rheumatism and arthritis (Klinefelter), 508–9
Riley, Edwin G.: Legal procedures in tuberculosis control, 659–62
Riley, R. H.: A report on the functioning of the County Medical Care Program, 517
Ringworm of the scalp, diagnosis and treatment (Robinson), 490–4
Roberts, Dean W.: Baltimore Study of Chronic Illness, 297–9
Robinson, G. Canby: Social service and rehabilitation in the treatment of tuberculosis, 70–72
Robinson, Harry M., Jr.: Diagnosis and treatment of ringworm of the scalp, 490–4
Robinson, R. C. V.: Dermatology (diet in), 178–9
Rubenstein, M. William, jt. auth., see Reich, Walter J.
Ruhräh, John, 205–7

Safety campaign movie, 221
St. Mary's County Medical Society, Members, 289
Sartwell, Philip E.: The effect of improved therapy on the sanatorium bed situation, 73–4
Sauer, Elmer P.: Tuberculosis treatment: past, present and future, 77–9
Scholarships, federal, proposed for students in medicine, 528
Schuman, William: Role of the Baltimore City Medical Society in the reorganization of Doctor's Hospital, 217–9
Seizures, dione drugs in petit mal (Baldwin), 601–9
Selective Service, advisory committee urges speedier processing, 348
Seminar: Recent advances in radiological studies of the vascular system, 635–43
Silverman, Charlotte: Role of the health department (in tuberculosis), 58–61
Skin diseases, Antibiotics in (Zeligman), 647–50
Smith, Dietrich C.: Postgraduate lecture course in basic sciences, 398
Social aspects of the adoption law (Waxter), 577–580
Somerset County Medical Society, Members, 289
South Dakota Board of Medical Examiners announces annual fee for licenses, 554
Stanley, John S., moderator, symposium on euthanasia, 120–40
State Practice Act, 441
Steinberg, Israel, jt. auth., see Dotter, Charles T.
Steiner, Walter Ralph, Memorial collection, 40–1
Stenosis, surgery for mitral and aortic (Glover), 547–54
Sterilization of the female (Baker), 483–4
Stewart, Mrs. Edwin H., Jr.: Auxiliary news, 53–4
Stone, Harvey B.,

  elected president of the Johns Hopkins Medical and Surgical Association, 227
  testimonial and presentation, annual meeting, 624–6
Stress incontinence in women, non-operative treatment (Wharton), 555–60
Strobel, Mrs. Martin E.:
  A Baltimore County plan, 163
  Membership, 666
Student nurses admitted to state schools, 572
Surgeon general of the Public Health Service establishes heart traineeships, 158
Surgeon, industrial, needed at Aberdeen, 91
Surgical treatment, bleeding esophageal varices (Linton), 400–11
Surgery
  indications for and results of, for mitral and aortic stenosis (Glover), 547–54
  of the autonomic nervous system, recent advances (Abbott), 3–24
Symposiums
  adoption law of Maryland, announcement, 37
    proceedings, 573–588
  on diabetes, 363–77
  on trauma, 306–28
  on tuberculosis, for general practitioners, 253
  on tuberculosis in Baltimore, 58–87

Talbot County Medical Society, Members, 289
Tax deferments on annuity payments, 213–4
Taylor, E. Don, obituary, 201
Telecast, closed circuit, University Hospital, 215–6
Television program, closed circuit, announced, 485
Thompson, Raymond K.: Traumatic unconsciousness, 143–6
Thorek, Philip: The acute abdomen, 355–63
Thrombosis, coronary, convalescence and later life (Love), 589–93
Thyroid and iron metabolism, interrelations (Danowski), 530–7
"Today's Health," magazine, 619
Trauma, symposium on, 306–28
Traumatic unconsciousness (Thompson), 143–6
Trimble, I. Ridgeway, Lectureship see Medical and Chirurgical Faculty of Maryland. Transactions
Tuberculosis,
  decline in mortality in Baltimore, 614
  pulmonary, the surgical approach (Brantigan), 228–36
Tuberculosis control, legal procedures (Riley), 659–62
Tuberculosis problem in Baltimore—past, present and future, symposium, 58–87
Tuberculosis symposium announced, 622
Tuberculosis symposium for general practitioners, second annual, 253

Unconsciousness, traumatic (Thompson), 143–6
United States Armed Forces
  discount reports on hepatitis rate, 200
  doctors in Korea to aid medical rehabilitation, 528
  examining station needs physicians, 634
  medical officers surveyed, 333
  Medical Service orientation conferences, Second Army area, 103
  150 medical graduates in Army's intern program, 386
  reviewing physical records of 1,000 priority 3 physicians, 226
  to reduce call on doctors, 221
  transferring physicians, 614
United States Medical and Dental Academy, 166
United States Public Health Service determining cost of free medical care for U. S. personnel, 613
University Hospital closed circuit telecast, 215–6
University of Maryland School of Medicine offers course in basic sciences, 398
Uterine bleeding, benign, treatment with intra-cavitary radiation (Hundley), 504–8

Vaccination records of children entering first grade (Hayman), 141–3
Vascular system, radiological studies, 635–43
Veterans Administration
  Council of Chief Consultants (Special Medical Advisory Group), 335
  hospitalizing more non-service connected cases, 617
  medical care for non-service connected cases, 567
  to call in Dept. of Justice on non-service connected cases, 658
Voluntary pension plans, 213–4

Waddell, William R.: Parenteral nutrition, 244–8
Wagley, Philip F.: Iron deficiency anemia, 351–5
Wagner, John A.: Relationship of biopsy to diagnosis, 349–50
Wainwright, Charles W., and Berthrong, Morgan: Clinical pathology conference, 189–200
Walker, A. Earl: Keeping up with advances in medicine, 55–6
Warner, C. Gordon, jt. auth., see Carey, T. Nelson
Washington County Medical Society, 39, 203–4, 252–3, 335
  Election of officers, 39
  Members, 289–90
Waxter, Thomas J. S.:
  Irregular discharges from tuberculosis hospitals from the point of view of social factors involved, 67–8
  Social aspects of the adoption law, 577–80
Weiss, Harvey: The role of the general hospital in tuberculosis, 74–5
Wharton, Lawrence R.: Non-operative treatment of stress incontinence in women, 555–60
Wicomico County Medical Society, 654–5, Members, 290–1
Williams, Charles H., letter from Charles M. Fleming, 149
Williams, Mrs. Charles H.:
  A.M.A. convention, Woman's Auxiliary, 521–522
  Remarks at annual meeting of the Faculty, 623–4
  report to A.M.A. Woman's Auxiliary, 344–5
Williams & Wilkins Co., appoints H. J. L. Marriott as consultant, 97
Wise, Walter D.: Presentation of volume of writings of Dr. Harvey G. Beck, 529
Wiswell, John G.: Laboratory tests in common endocrine disorders, 497–503
Woman's Auxiliary to the American Medical Association
  Conference, 1952, 52–3
  National convention, 226, 521–2

Woman's Auxiliary to the Baltimore City Medical Society, 393–4
  appreciation of contribution to the American Medical Education Foundation, 668
  "Evening in Paris" ball, announcement, 106
  Our first party (Cook), 104–5
Woman's Auxiliary to the Baltimore County Medical Society, 164, 393, 624
  awards nursing scholarship, 571
  officers, 164
Woman's Auxiliary to the Frederick County Medical Society, 394
Woman's Auxiliary to the Medical and Chirurgical Faculty of Maryland, 52–4, 220–1, 571–2, 618–9
  Address of the incoming president (Ball), 344
  annual meeting, program, 114
  Auxiliary nursing committee, 52–3
  contribution to the American Medical Education Foundation, 146
  Creative Art Show, 220
  Faculty ball, 220, 221
  given national recognition, 571–2
  Presidential appointments, 571
  President's message (Ball), 570–1
  report to A.M.A. Woman's Auxiliary (Williams), 344–5
  review of conventions, 520–2
  semi-annual meeting, 522
  sponsors "Future Nurses Day," 259
Woman's Auxiliary to the Montgomery County Medical Society, 162–3, 394–5
Woman's Auxiliary to the Prince George's County Medical Society, 395–6
Woman's Auxiliary to the Washington County Medical Society, 396, 619, officers, 164
Women's Clubs, how to work with (Davis), 618–9
Woodward, Lewis K., 57
  honored at World Medical Association conference, 385–6
Woodward, Theodore E., and Hightower, John A.: Protean clinical features of leptospirosis, 486–9
Worcester County Medical Society, Members, 291
World Medical Association conference, 99, 385–6

Yeager, George H.: Peripheral vascular disturbances, 375–7
  Thank you, Mr. McCormick, 2
  Word of appreciation to our editor (Chesney), 1
Yeager, Mrs. George H.: The annual meeting, Woman's Auxiliary, 520

Zeligman, Israel: Use and misuse of antibiotics in skin diseases, 647–50
Zeller, Henry, portrait presented to Washington County Medical Society, 252–3

UNIVERSITY OF CALIFORNIA
Medical Center Library

THIS BOOK IS DUE ON THE LAST DATE STAMPED BELOW

Books not returned on time are subject to a fine of 50c per volume after the third day overdue, increasing to $1.00 per volume after the sixth day. Books not in demand may be renewed if application is made before expiration of loan period.

~~APR 22 1955~~
~~DEC 27 1955~~
7
~~MAR 2 - 1956~~
~~APR 9 1956~~
~~MAY 15 1956~~
~~AUG 11 1956~~
RETURNED
NOV 24 1958

7 DAY
RETURNED
OCT 17 1959
OCT 17 1959
7
RETURNED
~~JAN 2 1960~~
7 DAY
RETURNED
JUN 1 1961
JUN 2 1961

7 DAY
JAN 27 1969
RETURNED
JAN 22 1969

5m-7,'52(A2508s2)4128

ST

95012